

**EMPLOYERS' LIABILITY ACCIDENT REPORT FORM**

Branch \_\_\_\_\_ Policy No \_\_\_\_\_ Claim No \_\_\_\_\_

*This form should be completed and returned to the Insurers immediately, whether a claim has been made on the insured or not.*

<p>1. Name in Insured ..... Address ..... Business .....</p>	<p>Phone No.....</p>
<p>2. (a) Name and address of injured person ... (b) Usual occupation ..... (c) Is he in your direct employ? If so state length of service ..... (d) TRN Number .....</p>	<p>Date of Birth..... Married or single..... Average weekly wage after deduction of income taxes...\$</p>
<p>3. (a) Date and time of accident ..... (b) Place of accident ..... (c) When was the accident first reported to you and by whom? .....</p>	
<p>4. (a) Nature and extent of injury ..... If to arm or hand, state whether right of left ..... (b) Has the injured person returned to work?</p>	
<p>5. (a) State precisely what he was doing, and how the accident occurred ..... (If the accident was due to any defect in machinery or plant, state nature thereof. It is essential that any defective parts should be retained.) (b) Was he performing a duty for which he was employed? ..... (c) Was he disobeying any rule or order? ... (d) Who was in charge? ..... (e) Was accident due to another person's negligence? If so, give particulars ...</p>	
<p>6. Has any communication, verbal or written, been made to you by or on behalf of the injured person? If so, give particulars. (Any written communications received must accompany this form.)</p>	
<p>7. Names and addresses of witnesses of accident .....</p>	

I/We hereby declare that, to the best of my/our knowledge and belief, the above statements are fully true and truly made, and that I/we have not withheld any material fact concerning the accident or the injured person.

Date \_\_\_\_\_ 2000

Employer's  
Signature \_\_\_\_\_

(Affix official stamp).