BRITISH CARIBBEAN INSURANCE COMPANY LIMITED
Head Office: 36 Duke Street, P.O. Box 170, Kingston, Jamaica, W.I.
Tel: (876) 922-1260, (876) 618-2242; Fax: (876) 922-4475

Private and Confidential. **Claim No ……...….**

Answering these questions does not imply that the injured person is making, or will make, a claim.

Preliminary particulars of accident are to be furnished by the Employer.

EMPLOYER:

Name _____

Address_____

Business_____Policy No._____

Telephone Nos. (W)_____ (H) _____ (C) _____

Present No. of Employees _____ Amount of last week's total wages _____

INJURED PERSON:

Name _____ Occupation _____

Address_____ Age_____ Department_____

Was he/she in your direct employment? [ ] yes [ ] no If so, since what date? _____

Name and Address of Injured Person's Doctor_____

_____

If the person is a male, please state:- (1) Whether married _____ (2) No. of Children under age of 16_____

Name of Hospital taken to_____ In or out-patient? _____

Is he/she likely to be totally disabled for a longer period than three (3) days? [ ] yes [ ] no

ACCIDENT:

Date _____Time _____ Place _____

Did he/she work after the accident? [ ] yes [ ] no If so, to what date? _____

Was it reported? [ ] yes [ ] no (1) If so, to whom? _____

(2) On what date? _____

_____

Description of the Accident:

What was general nature of work going on? _____

Was machinery being used? [ ] yes [ ] no

If so, please state exactly what machinery was involved in the accident_____

_____

What motive power was employed for machine? _____

What actually occurred to cause accident? _____

_____

Was it caused by:- Plant not owned by you? [ ] yes [ ] no

Anyone not employed by you? [ ] yes [ ] no

Was he/she doing his/her ordinary work? [ ] yes [ ] no

If not, what was he/she doing? _____

Nature of injury _____

_____

Name(s) of Witness(es) who actually saw the accident _____

_____

Further information, if any _____

_____

The above replies are correct to the best of my knowledge and belief.

Signature of Employer .....

Date.....20…….....

The Statement below need NOT be completed if a claim is not likely to arise.

Statement of Injured Person's Weekly Cash Earnings

The Employer is requested to state below details of the Wages paid by him to the Injured Person in each week for 52 weeks prior to the Date of the Accident, or such shorter period as he may have been employed. If absent or time lost in any week or weeks, state reason.

N.B. – The earnings must be stated in full.

Week Ending			Week Ending			Week Ending		
			Brought forward			*Brought forward*		
Carried forward			*Carried forward*				*Total*	