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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.

1. Name of Insured _____
   Address _____
   Business _____
   Phone No. _____

2. Name of Injured person _____
   Address of Injured person _____
   Usual occupation _____
   Is he in your direct employ? ◯ Yes ◯ No
   If so state length of service _____
   Age _____ Marital Status _____
   Average weekly wage after deduction of income taxes _____

3. (a) Date of Accident _____ Time of Accident _____
   (b) Place of Accident _____
   (c) When was the first accident reported to you and by whom?
   Date of Accident _____ By Whom _____

4. (a) Nature and extent of injury _____
   (b) Has the injured person returned to work? ◯ Yes ◯ No

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 retainted.)
   _____
   (b) Was he performing a duty for which he was employed? ◯ Yes ◯ No
   (c) Was he disobeying any rule or order? ◯ Yes ◯ No
   (d) Who was in charge? _____

(e) Was accident due to another person's negligence? ◯ Yes ◯ No

If so, give particulars

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.)

7. Names and addresses of witnesses of accident

Name of witness

Address of witness

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. I/We further declare that the statements above can be relied upon in the contemplation of litigation proceedings which may arise.

Date

Employer's Signature

(affix official stamp)

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