INSURANCE COMPANY JAMAICA LIMITED

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EMPLOYERS' LIABILITY CLAIM

POLICY NO. AND RENEWAL DATE			
PREMIUM PAID TO		ISSUING COMPANY	
BRANCH			
Have you any other policy in *force* covering your liability as an employer?	☐ Yes	☐ No	
If so, please give name of Company/Companies and Policy Number(s)			

FOR OFFICE USE	
CLAIM NO.	
CHECKED BY	

EMPLOYER'S NAME		ADDRESS	
TRADE OR BUSINESS		TELEPHONE NO.	
		EMAIL ADDRESS	

EMPLOYEE'S NAME				ADDRESS	
OCCUPATION		AGE		EMAIL ADDRESS	
INDICATE PHYSICAL DEFECTS (IF ANY) APART FROM PRESENT ACCIDENT					
STATE MARITAL STATUS		STATE NO. OF CHILDREN		DATE OF COMMENCEMENT OF EMPLOYMENT	
IF AN APPRENTICE, WHEN DOES APPRENTICESHIP FINISH?					
WAS THE INJURED PERSON IN YOUR DIRECT EMPLOYMENT AND PAY?	☐ YES	☐ NO			
IF NOT WAS HE/SHE IN THE EMPLOY OF A CONTRACTOR TO YOU?	☐ YES	☐ NO			

IMPORTANT NOTE If any claim is received, please advise us immediately and forward EMPLOYERS' LIABILITY CLAIM

Statement of weekly wages/salary of injured employee for the past twelve months

Week commencing _____ to week ending _____

WEEK	GROSS AMOUNT		NET AMOUNT i.e. after deduction of Income Tax and NIS contributions		WEEK	GROSS AMOUNT		NET AMOUNT i.e. after deduction of Income Tax and NIS contributions		WEEK	GROSS AMOUNT		NET AMOUNT i.e. after deduction of Income Tax and NIS contributions	
1					B/F					B/F				
2					19					36				
3					20					37				
4					21					38				
5					22					39				
6					23					40				
7					24					41				
8					25					42				
9					26					43				
10					27					44				
11					28					45				
12					29					46				
13					30					47				
14					31					48				
15					32					49				
16					33					50				
17					34					51				
18					35					52				
C/F					C/F					Total				

I/We hereby declare the above wages/salary particulars to be true in every respect

SIGNATURE OF EMPLOYER _____ DATE _____

DESCRIBE THE NATURE OF THE INJURIES

IF REMOVED TO HOSPITAL OR OTHERWISE MEDICALLY EXAMINED, PLEASE STATE NAME AND ADDRESS OF DOCTOR OR HOSPITAL

STATE DATE ON WHICH EMPLOYEE			
a) Left off work		b) Returned to any part of former work	
c) If not yet returned, state date employee is expected to return (*if known*)			
d) If accident terminated fatally, give DATE OF DEATH			

DATE OF ACCIDENT		TIME		
WHEN WAS THE ACCIDENT FIRST REPORTED TO YOU OR YOUR REPRESENTATIVE?				
IF NOT REPORTED TO YOU, TO WHOM WAS THE ACCIDENT REPORTED				
WAS THIS INCIDENT WITNESSED BY ANYONE?	☐ YES	☐ NO		
IF YES, STATE NAME AND ADDRESS OF WITNESS				
HAS THE OCCURRENCE BEEN ENTERED IN YOUR ACCIDENT BOOK?	☐ YES	☐ NO		
WHERE DID THE ACCIDENT OCCUR?				
NATURE OF WORK BEING PERFORMED AT TIME OF ACCIDENT				
IF THE ACCIDENT IS CONNECTED WITH MACHINERY				
(a) WAS IT PROPERLY GUARDED?	☐ YES	☐ NO	(b) WAS THE GUARD IN USE?	☐ YES ☐ NO
(c) HAS H.M. FACTORY INSPECTOR EXAMINED SINCE THE ACCIDENT?	☐ YES	☐ NO		
WHAT NEGLIGENCE IS ALLEGED?				
IS THERE ANY SUSPICION THAT THE INJURED EMPLOYEE WAS				
(a) UNDER THE INFLUENCE OF DRINK?	☐ YES	☐ NO		
(b) VIOLATING ANY OF THE RULES OF THE ESTABLISHMENT?	☐ YES	☐ NO		
NAME AND POSITION OF OVERSEER OR PERSON IN AUTHORITY OVER THE INJURED EMPLOYEE				

DESCRIPTION OF THE ACCIDENT

I/We certify that the foregoing statement is a true account of my/our knowledge and belief

SIGNATURE OF EMPLOYER _____ DATE _____

NOTE: (a) The designation of the person signing must be given (b) Signature must also be given below statement of wages/salary on previous page	If injuries are likely to prove fatal, contact Head Office at once

EMPLOYERS' LIABILITY CLAIM

In any correspondence
concerned with this information,
please quote the following:

CLAIM NO.

DATE OF ISSUE
OF REPORT FORM

THIS FORM SHOULD BE RETURNED
WITHIN TWO DAYS TO ENSURE
PROMPT ATTENTION

Please complete this form answering **all** questions relevant to the accident and return as quickly as possible.

This report is required for the information of our Solicitor only to enable him to prosecute or defend proceedings in the event of litigation arising out of matters referred to in the report

You are reminded that we cannot hold ourselves responsible for any payments made to injured employees without our authority.

If an accident has in any was been caused by machinery, no alteration in such machinery should be made without first obtaining our authority

IMPORTANT

If any claim is received, please advise us immediately and forward the letter unanswered.

FORM ISSUED BY

GENERAL ACCIDENT INS. CO. JA. LTD.

OFFICE OF ISSUE

Print Form

Revised: July 7,2010