GENERAL INSURANCE Company Limited

19-21 Knutsford Boulevard, P.O. Box 514, Kingston 5, Jamaica, West Indies.
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PUBLIC LIABILITY CLAIM FORM

1 Name of Insured.....

Business.....

Address.....

Policy No..... Date if payment of last premium.....

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2 Name of Injured Person.....

Address.....

Occupation..... Age.....

3 (a) Was the injured person in your direct employ?	(a).....
3 (b) If not, give name and address of Contractor	(b)..... .....
4 How long had the injured person been employed by you?	
5 (a) When did the accident occur? (Date and Time)	(a).....
5 (b) Where did it happen?	(b).....
6 (a) When was the accident first reported by the injured person, and to whom?	(a).....
6 (b) When did he cease work?	(b).....
7 State the general nature of the work upon which the injured person was engaged at the time of the accident. Was the injured person carrying out his duties in the usual and proper manner?	
8 (a) State through whose fault (if any) it occurred	(a).....

8 (b)	Was the injured person guilty of any insobriety, misconduct or disobedience to others? If so please give full particulars	(b)…… ……
9	Describe in detail how the accident occurred. If from machinery state type and how driven (i.e. steam, gas, electrical, etc.) If from a fall state the cause of it (What work was being performed?)	
10	Names and Addresses of witnesses:	
	(a) Name	Address…… ……
	(b) Name	Address…… ……
	(c) Name	Address…… ……
11	(a) State nature of injures	(a)……
	(b) Is he receiving medical attention?	(b)……
	(c) If so, give name and address of doctor or hospital	(c)……
12	(a) Has the injured worker returned to work?	(a)……
	(b) If so, state date	(b)……
	(c) How long do you think he will be away from work?	(c)…… ……
13	What are the wages of the employee?	
	(a) Hourly	(a)……
	(b) Weekly	(b)……
	(c) Monthly	(c)……

…… ……

DATE SIGNATURE OF INSURED