CG | UNITED

EMPLOYER'S LIABILITY ACCIDENT REPORT

CLAIM NO. _____

Please print clearly in BLOCK LETTERS throughout. Answer all questions, selecting the necessary check box as appropriate and indicating Not Applicable if required. Date format is DD/MM/YY. This form, together with the Wages Statement overleaf, must be completed and returned to the Company immediately.

Branch/Agent _____

Policy No. _____ VAT No. _____

SECTION 1 CLAIM DETAILS

1. Employer/Insured Name _____ Tel No. _____
   Email _____ Cell No. _____
   Business _____
2. Date, time and place of accident _____
   When was the accident first reported to you and by whom? _____
   Names and Contact Details of Witnesses _____
   _____
3. Name injured person _____ Date of Birth _____
   Usual occupation _____
   Address _____
   Where is injured person at present? _____
   Does he reside with you? ☐ Yes ☐ No Are you? ☐ Married ☐ Single ☐ Divorced
   Relationship to Employer (if any) _____
   When did he enter your service? _____
   Is the injured person in your regular employment? ☐ Yes ☐ No
   Indicate if he is: ☐ in your direct employ or ☐ in that of a sub-contractor
   If the latter, state the name and address of the sub-contractor _____
   _____
4. Noting the definition below, please select which of the following is applicable to you:
   ☐ Politically Exposed Person (PEP) ☐ Related to a Politically Exposed Person (PEP) ☐ Not Applicable

   *A **Politically Exposed Person** (PEP) is one who has been entrusted with prominent public functions, for example a head of state or of government, senior politicians, senior government, judicial or military officials, senior executives of state-owned corporations, important political party officials. This category also includes immediate family members close personal and professional associates.*
5. State precisely what he was doing, and how the accident occurred (if the accident was due to any defect in machinery, scaffolding or other equipment, state nature thereof):

   Was he performing a duty for which he was employed? ☐ Yes ☐ No Was he disobeying any rule or order? ☐ Yes ☐ No
   Who was in charge? _____
   Was accident due to another person's negligence? ☐ Yes ☐ No If so, give particulars:
6. Nature and extent of injury. If to arm or hand, state whether right or left.
7. Did he stop work immediately? ☐ Yes ☐ No if No, when did he stop? Date _____ Time _____
   If taken to a hospital, state which and whether ☐ in-patient or ☐ out-patient _____
   Is he disabled now? ☐ Yes ☐ No If No, when did he resume work? _____
   What is the probable further duration of disablement? _____

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8. Is there any other information regarding the accident or the injured person with which the company should be acquainted?

9. Have you any other insurance or indemnity covering accidents to your employees? ☐ Yes ☐ No If Yes, give particulars:

SECTION 2 STATEMENT OF EARNINGS

Statement of the injured person's earnings from me/us during the TWELVE MONTHS PRECEDING THE ACCIDENT, or during the period of his employment, if shorter. If he has been absent from work for any part of the period please enter "nil" in the wages column AND STATE THE REASON.

Week ended			Cash wages			Week ended			Cash wages			Week ended			Cash wages		
	Month	Day					Month	Day					Month	Day			
1							Bt. FWD	$					Bt. FWD	$			
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					
Carried forward $						Carried forward $						**Total $**					

State whether there are any other earnings or prerequisites such as board and/or lodging, rent, allowances in kind, etc.

_____

If so, give: (a) Full description _____

(b) Estimate of value thereof per annum $ _____

SECTION 3 DECLARATION

I/We hereby declare that the foregoing particulars provided by me/us are true and correct to the best of my/our knowledge and belief. I am/we are aware that the failure by me/us to provide information that is true and correct to the best of my/our knowledge and belief, or the withholding of information relevant to this claim may result in CG United Insurance TT Ltd. denying or voiding this claim, or in criminal prosecution and/or civil proceedings being brought against me/us in accordance with relevant Laws.

Name (if not Insured) _____ Title/Position _____

Employer's Signature: _____ Date _____

FOR OFFICE USE ONLY	Total Earnings $	Average per week $