

# The Insurance Company of the West Indies Limited

## EMPLOYERS NOTICE OF INJURY FORM

This Form should be returned, fully completed by Employer, to 2 St. Lucia Avenue, Kingston 5, Tel: 92-69182-5, 92-69040-5

within 48 hours after the accident

ALL QUESTIONS MUST BE ANSWERED IN DETAIL

Name of Employer \_\_\_\_\_

Address \_\_\_\_\_

Occupation \_\_\_\_\_ Policy No. \_\_\_\_\_

<p>1. Name of Injured Person:</p>	Age _____
<p>2. Address</p>	Occupation _____
<p>3. Date Employment commenced</p>	_____
<p>4. Was the injured Person in your direct employ? If not give name and address of employer.</p>	_____
<p>5. State (1) Time (2) Date (3) Place of Accident.</p>	(1) _____ (2) _____ (3) _____
<p>6. Have you received a formal notice of the accident. If so (1) when (2) in what form:</p>	(1) _____ (2) _____
<p>7. Describe briefly how accident happened (see below):</p>	_____ _____ _____
<p>8. If machinery was involved (1) was a guard provided (2) was it being used?</p>	(1) _____ (2) _____
<p>9. Was it during the proper performance of his /her work?</p>	_____ _____
<p>10. Who witnessed the accident?</p>	_____ _____
<p>11. On what date did the injured person cease work?</p>	_____ _____
<p>12. State shortly the nature of the injuries received and whether the injured person is able to perform any part of his/her duties.</p>	_____ _____ _____ _____
<p>13. Probable period of disablement:</p>	_____ _____
<p>14. Is the workman paid daily or otherwise? When was he last paid?</p>	_____ _____
<p>15. Where is the injured person receiving medical treatment? State if admitted to hospital.</p>	_____ _____
<p>16. Has the injured person (1) resumed work, if so state date (2) been certified fit by doctor, if so date.</p>	(1) _____ (2) _____

IF ACCIDENT WAS CAUSED BY (1) WORKMAN'S DISOBEDIENCE OR MISCONDUCT (2).. WORKMAN UNDER THE THE INFLUENCE OF DRINK OR DRUGS OR BREAKING ANY RULE OR ORDER (3) ANY DEFECT IN EMPLOYERS BUILDING OR EQUIPMENT (4) THE FAULT OR NEGLIGENCE OF ANY OTHER PERSON (5) PRE-EXISTING SICKNESS OR DISEASE OF WORKMAN - GIVE FULL PARTICULARS IN SPACE PROVIDED OVERLEAF.

I/We certify that the above statement and information supplied overleaf is true and complete to the best of my/our knowledge and belief.

Employer's Signature \_\_\_\_\_ Date \_\_\_\_\_

It is necessary that the fullest information should be given in order to avoid delay and the trouble to policy holders of subsequent correspondence.

**THE INSURERS DO NOT ADMIT LIABILITY BY THE ISSUE OF THIS FORM**

PLEASE TURN OVER

# STATEMENT OF INJURED PERSON'S WEEKLY CASH EARNINGS

(For 52 Weeks Immediately before accident)

N.B.

IF INJURED PERSON HAS NOT BEEN CONTINUOUSLY (NO BREAK OF OVER 14 DAYS) EMPLOYED FOR A FULL YEAR, START FROM DATE OF ACCIDENT AND GIVE WEEKLY WAGES UP TO EITHER THE DATE THE WORKMAN WAS FIRST EMPLOYED OR TO WHERE A CLEAR BREAK OF FOURTEEN DAYS IS REACHED.

IF THERE IS NO RECORD OF INJURED PERSON'S WAGES STATE AVERAGE ESTIMATED WEEKLY WAGE IF INSURED PERSON ONLY TEMPORARILY EMPLOYED OR ONLY WORKED VERY SHORT DURATION STATE AVERAGE WEEKLY WAGE OF PERSON IN SIMILAR EMPLOYMENT.

Week Ending (Date)	Wages	Week Ending (Date)	Wages	Week Ending (Date)	Wages
1		Forward		Forward	
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	
Forward		Forward		Total	

MONTHLY AVERAGE: .....

WEEKLY COMPENSATION: .....

CLAIM SETTLED FOR: .....

PERIOD OF INCAPACITY: .....

PAID ON: .....

PLACE FOR FURTHER PARTICULARS