GK GENERAL INSURANCE Company Limited

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

Claim No. _____
Policy No. _____ Date of Policy _____ Date of Last Renewal _____

POLICYHOLDER-

1. Name (in full)	1.
2. Occupation	2.
3. Address	3.
4. E-mail Address	4.
5. In connection with what trade or business did you employ the injured person?	5.
6. Are you insured elsewhere against this risk? If so, give name of Company.	6.

PARTICULARS OF INJURED PERSON-

1. Name	Date of Birth
2. Occupation	Married or Single
3. Address	Number of children under 15
4. Is (s)he related to you? If so, state relationship	Does (s)he reside with you?
5. (a) Is (s)he in you direct employ?	5. (a)
(b) Is (s)he in your sole employ?	(b)
(c) Since what date?	(c)
6. If in the service of a Sub-Contractor, give the name and address of the Sub-Contractor	6.

THE ACCIDENT

1. State the Date, Hour and Place of Occurrence	1. Date _____ Hour _____ Place _____
2. State when Injured Employee ceased work	2. Date Hour

3. Describe fully how the accident happened:- _____

4. State precisely the duties of the Injured Employee when accident occurred	4.
5 What was the general nature of the work going on?	5
6. What machinery was in use in connection with the work?	6.
7. (a) Give date he injured person first reported the accident.	7. (a)
(b) To whom was it reported?	(b)
8. Did the accident occur during his/her working hours?	8.
9. Was (s)he sober?	9.
10. (a) Was (s)he guilty of any misconduct or disobedience to orders?	10 (a)
(b) If so, give particulars	(b)

11. (a) Was the accident due to negligence upon the part of any person?	11 (a) _____
(b) If so, give name, and state whether such person is in your direct employ.	(b) _____
12. Names and address of any witnesses of the accident.	12. _____
	_____
	_____

THE INJURY

1. State very fully the nature and extent of the injury	1. _____
N.B. - If to a limb, state whether right or left.	_____
2. (a) Is the Injured Employee able to attend to any portion of his/her work?	2. (a) _____
(b) If so, what is the value of his/her present service?	(b) _____
3. What is the likely duration of incapacity?	3. _____
4. Where was (s)he taken after the accident?	4. _____
5. Where is (s)he now?	5. _____
6. Name and address of Doctor in attendance	6. _____

GENERAL INFORMATION-

Give all such details respecting the Accident and the Injured Employee as would be of assistance to the Company.

What are the wages of the employee?

Weekly _____

Monthly _____

I/We the undersigned Insured hereby declare that the above statements and facts are true and that I/We have not withheld from the Company any information within my/our knowledge connected with the claim.

Date _____ Signature of Insured _____

Please enclose medical certificate, if available

N.B. - The Company does not admit liability by the issue of this Form.