

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? _____



EMPLOYER'S LIABILITY ACCIDENT REPORT

CLAIM NO. _____

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 Ltd. denying or voiding this claim, or in criminal prosecution and/or civil proceedings being brought against me/us in accordance with relevant Laws.

Data Protection Declaration:

By signing this form, I confirm/understand that:

- In order to administer the policy and plan CG United Insurance Ltd. may process any and all of the personal data provided.
- I consent to CG United Insurance Ltd. processing my personal data, in accordance with CG United Insurance Ltd.'s Privacy Policy (<https://international.cgcoralisle.com/privacy-policy/>). For additional information on your rights and how to exercise them, please access or request this Policy.
- I confirm that any personal data I provide to CG United Insurance Ltd. in respect of any third party, is done with that third party's consent and knowledge of CG United Insurance Ltd. processing of their personal data.
- I have the right for my personal data to be processed in accordance with the rights of Data Subjects under the relevant jurisdictional privacy legislation.
- I understand that this form shall be incorporated into and shall constitute a part of the policy contract between me/us and the Company.

Name (if not Insured) _____ Title/Position _____

Employer's Signature: _____ Date _____

FOR OFFICE USE ONLY	Total Earnings \$
----------------------------	-------------------

Average per week \$
