

## EMPLOYERS' LIABILITY ACCIDENT REPORT FORM

Branch  Policy No.  Claim No.

This form should be completed and returned to the Insurers *immediately*, whether a claim has been made on the insured or not.

1. Name of Insured   
Address   
Business   
Phone No.

2. Name of Injured person   
Address of Injured person   
Usual occupation

Is he in your direct employ?  Yes  No

If so state length of service

Age  Marital Status

Average weekly wage after deduction of income taxes

3. (a) Date of Accident  Time of Accident

(b) Place of Accident

(c) When was the first accident reported to you and by whom?

Date of Accident  By Whom

4. (a) Nature and extent of injury

(b) Has the injured person returned to work?  Yes  No

5. (a) State precisely what he was doing, and how the accident occurred (If the accident was due to any defect in machinery or plant, state nature thereof. It is essential that any defective parts should be retained.)

(b) Was he performing a duty for which he was employed?  Yes  No

(c) Was he disobeying any rule or order?  Yes  No

(d) Who was in charge?

(e) Was accident due to another person's negligence?

Yes  No

If so, give particulars

6. Has any communication, verbal or written, been made to you by or on behalf of the injured person? If so, give particulars. (Any written communications received must accompany this form.)

7. Names and addresses of witnesses of accident

Name of witness

Address of witness

I/We hereby declare that, to the best of my/our knowledge and belief, the above statements are fully true and truly made, and that I/we have not withheld any material fact concerning the accident or the injured person. I/We further declare that the statements above can be relied upon in the contemplation of litigation proceedings which may arise.

Date

Employer's Signature

\_\_\_\_\_

(affix official stamp)