

EMPLOYER'S LIABILITY CLAIMS FORM

Policy No.						Dat	e D I	о М М	2 0 Y
The Company does not admit bout this accident, please do Coronation immediately.									
PARTICULARS OF	ACCIDENT								
Name									
Address									
Email									
Date of payment of the last p	remium	D D M	M 2 0 Y	Υ	L	ast Premium			
Business or occupation				Tele	phone				
Agent / Broker				Tele	phone				
Name							Age	е	
Address									
ength of service		Oc	cupation						
Marital Status		State numbe	r of children under 15	5 years of a	age				
s the employee: In direct emp	oloyment		Or a Contractor		ls	employee a re	elative	Yes	No
f so, please State relationship)								
Section (Block of all of the conduction		2 -12		v					
s the workman in receipt of c Did the workman suffer from Where is he presently?	compensation for a pr	revious disability? prior to the accide	nt?	Yes Yes Yes	No No No				
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EMPLOYER'S LIABILITY CLAIMS FORM

workmen's compensation ordinances.

IF ACCIDENT	WAS (AUSEI) BY MACE	HIMEDA DI EVZE			
		IIIVERT, FEEASE	JIAIL.		
(a) description an	d motive power				
(b) whether mach	ninery was fenced or protected?	?			
(c) to whom same	e belongs				
If accident occur	red away from employer's prem	nises, please state:			
(a) nature of worl	k or contract				
(b) whether you a	are the chief contractor				
DECLARAT	TON				
deal on My/Our l	foregoing answers are true and behalf with the third party clain d your solicitors on My/Our bel	ns arising herein, in a	ccordance with the terms ar	nd conditions of the above-r	• • •
•	claims and any litigation arising		missions and settlements giv	e such consents as you may	consider necessary for the
	D D M M 2	0 Y Y			
	Date Inst	ured		Signature	
	ttention is particularly drawn to upon the amount of claims pai				as the future premiums poyable
laturally depend	upon the amount of claims par	d by the company. I	e silodia tilerefore do every	tilling to prevent any but bot	na nue ciaims being aumiteu.
STATEMEN	IT OF WAGES				
Detailed stater	nent of weekly wages earne	ed by			For 12 mo
	date of his/her accident for		s he/she may have been	in his/her employer's se	rvice.
period to the t	date of file, fiel decident for	such less period o	is ne, she may have been	in mo, ner employer 5 se	11100.
WEEK ENDING	WAGES	WEEK ENDING	WAGES	WEEK ENDING	WAGES
1		18		35	
2					
2		19		36	
3		19 20		36 37	
3		20		37	
3		20 21		37 38	
3 4 5		20 21 22		37 38 39	
3 4 5 6 7 8		20 21 22 23 24 25		37 38 39 40 41 42	
3 4 5 6 7 8 9		20 21 22 23 24 25 26		37 38 39 40 41 42 43	
3 4 5 6 7 8 9		20 21 22 23 24 25 26 27		37 38 39 40 41 42 43 44	
3 4 5 6 7 8 9 10		20 21 22 23 24 25 26 27 28		37 38 39 40 41 42 43 44 45	
3 4 5 6 7 8 9 10 11		20 21 22 23 24 25 26 27 28 29		37 38 39 40 41 42 43 44 45 46	
3 4 5 6 7 8 9 10 11 12 13		20 21 22 23 24 25 26 27 28 29 30		37 38 39 40 41 42 43 44 45 46 47	
3 4 5 6 7 8 9 10 11 12 13 14		20 21 22 23 24 25 26 27 28 29 30 31		37 38 39 40 41 42 43 44 45 46 47 48	
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If the injured workman has been absent from work at any time juring the period above specified, the date of such absence should be given as well as the reason