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EMPLOYER'S NOTICE OF A CLAIM MADE BY AN EMPLOYEE

EACH OF THESE QUESTIONS MUST BE ANSWERED COMPLETELY

(Please use block capitals and do not leave blanks or answer a question with a dash)

SECTION A – THE PARTIES

DETAILS OF EMPLOYER

Policy Number_____ Claim Number_____

Full Name of Employer_____

Address _____

Business Activities_____ _____

DETAILS OF EMPLOYEE

Name of Employee _____

Present Address _____

Previous Address _____

Date of Birth _____ Date of Joining Company_____
mm/dd/yy mm/dd/yy

Employee's present job title _____

Employee's present job description _____

If different from above
Original job title _____
Original job description _____

Is the employee alive or deceased? _____If "deceased", date of death _____
mm/dd/yy

Is the employee right or left handed? _____

Is employee in your direct employ? YES ☐ NO ☐

If "NO" in whose employ? _____

Relationship of direct employer to you? _____

DETAILS OF EMPLOYEE'S DEPENDANTS (if any)

Are there any dependants YES ☐ NO ☐

1. _____ Age _____
2. _____ Age _____
3. _____ Age _____
4. _____ Age _____
5. _____ Age _____
6. _____ Age _____

SECTION B – USE OF THE FORM (Select the relevant option)

1. The employee named above has been injured in an accident and I/we believe that I/we am/are liable to him/her for Workmen's Compensation Act injury benefits (Parts II and III of the Act) or at Common Law **COMPLETE SECTION C AND SECTION E OF THE FORM**

2. The employee named above has made a claim on me/us as his/her employer in respect of an occupational disease (Workmen's Compensation Act Part IV)
COMPLETE SECTION D AND SECTION E OF THE FORM

SECTION C -THE EMPLOYEE HAS SUFFERED OR CLAIMS TO HAVE SUFFERED A SUDDEN INJURY

1. On what date is it alleged that the injury was sustained? _____
mm/dd/yy

2. (a) Describe in detail how the accident occurred _____

_____

_____

(b) State the nature of the injury_____

3. Was the employee instructed to be on location by an official? YES □ NO □
If "YES", by whom?_____

4. Were the activities of the employee supervised? YES □ NO □
If "YES", by whom _____and give details_____

_____

_____

_____

5. Was First Aid treatment administered? YES □ NO □
If "YES", on _____ by _____ at location_____
mm/dd/yy

6. Was the employee taken to a Medical Facility? YES □ NO □
Name of Medical Facility _____

7. If "YES", was the employee admitted as an '"in" □ or outpatient □ ?

8. How did you receive the notice of injury/claim? Orally □ Letter □ Writ □
If "Letter" or "Writ", please attach copy.

9. Location where the incident occurred _____

10. Please give names and addresses of witnesses if possible
1. Name _____ Address _____
. 2. Name _____ Address _____

11. Date injury was reported _____ 12. Date employee ceased work _____
mm/dd/yy mm/dd/yy

13. Has the injured employee returned to ordinary work? YES □ NO □
If "YES" the work resumption date _____
mm/dd/yy

14. Has the employee returned to partial work? YES □ NO □
If "YES" resumption date _____
mm/dd/yy

15. Were the injuries inflicted by machinery? YES □ NO □
If "YES", list safety procedures _____

_____

_____

_____

16. Was the evidence of the injury retained? YES □ NO □
If "YES" provide detailed list, if "NO", seek to obtain _____

_____

_____

17. Do you think that at the time of the injury, the injured employee was:
Sober? YES □ NO □
Under the influence of drugs? YES □ NO □

18. Was the injured employee negligent? YES □ NO □

SECTION D – OCCUPATIONAL DISEASE

1. Date employee notified you of pending claim _____
   mm/ddyy

2. How were you notified? Orally □ Letter □ Writ □
   If "Letter" or "Writ", please attach copy.

3. Is the disease listed in the First Schedule of the Act? YES □ NO □

4. Name of the disease _____

5. Does the employee have a medical report? YES □ NO □
   If "YES" attach copy.

6. Describe aspects of present employment that allegedly caused the disease
   _____
   _____
   _____

7. List previous employers, begin with the most recent
   (i) _____
   (ii) _____
   (iii) _____
   (iv) _____

SECTION E – THE STATEMENT OF WAGES

STATEMENT OF WAGES earned by _____

Employed by _____ for twelve months prior to the date of the Accident, or for such shorter period as the employee may have been in the Employer's Service.

Week Ending mm/dd/yy	Wages		Week Ending mm/dd/yy	Wages		Week Ending mm/dd/yy	Wages	
1.			19.			37.		
2.			20.			38.		
3.			21.			39.		
4.			22.			40.		
5.			23.			41.		
6.			24.			42.		
7.			25.			43.		
8.			26.			44.		
9.			27.			45.		
10.			28.			46.		
11.			29.			47		
12.			30.			48.		
13.			31.			49.		
14.			32.			50.		
15.			33.			51.		
16.			34.			52.		
17.			35.			**TOTAL (1 – 52)**		
18.			36.					

The object of this form is to ascertain the exact average monthly earnings of the injured employee. It is essential that it should be carefully and correctly filled in. If the employee has been absent from work at any time during the period of employment such time must be specified and the reason for absence stated.

I/We certify that all the particulars given on this form are true to the best of my/our belief.

I/We understand that completion of this form does not constitute agreement that any claim is admissible under the noted policy.

Signature of Employer (If an individual/sole trader)

_____

Company Stamp

Position/Job Title (If Employer is a Partnership/Company)

_____

Date _____
mm/dd/yy

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Continuous period from _____ to _____ being _____ days

Wages earned during this period _____

$ _____ Monthly wages

$ _____ Half-monthly compensation from _____

$ _____ Compensation from _____ to _____ being _____days