Guardian Group
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EMPLOYER'S NOTICE OF A CLAIM MADE BY AN EMPLOYEE
(For use with Employer's Liability/Workmen's Compensation "Claims Made" Policies)

SECTION A – THE PARTIES **(Please answer all questions completely)**

DETAILS OF EMPLOYER:

Full Name of Employer

____

Address

____

Policy Number _______________ WCC _________Business_____________________________________

DETAILS OF EMPLOYER:

Full Name of Employee

____

Present Address

____

Previous Address

____

Date of Birth DD ________ MM _________ YR ________ Date of Joining DD ________ MM ________ YR ______

Is the employee right or left handed? RIGHT □ LEFT □

Is the employee alive □ or deceased □ ? If "deceased", date of death DD __________ MM __________ YR _________

Employee's present job title

____

Employee's present job description

____

If different from above

Original job title

____

Original job description

____

Is employee in our direct employer 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 _______________	4. ____________________	Age _______________
2. ____________________	Age _______________	5. ____________________	Age _______________
3. ____________________	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 below has made a claim on me/us and his/her employer in respect of an occupational disease (Workmen's Compensation Act Part IV) **COMPLETE SECTION D AND SECTION E OF THE FORM**

IF APPLICABLE DESCRIPTION IS 1 □ COMPLETE SECTION C & E
IF APPLICABLE DESCRIPTION IS 2 □ COMPLETE SECTION D & E

SECTION C – THE EMPLOYEE HAS SUFFERED/CLAIMS TO HAVE SUFFERED A SUDDEN INJURY

1. On what date is it alleged that the injury was sustained? DD __________ MM _________YR _____________
2. Describe in detail the nature of the alleged 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 DD _________ MM _________ YR __________
   By _______________________________at location ____

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 □ (attach copy) writ □ (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 DD __________________ MM _________________ YR _______________

12. Date employee ceased work DD __________________ MM _________________ YR_______________

13. Has the injured employee returned to ordinary work? YES □ NO □

    If "yes" - the work resumption date DD ______________ MM ________________ YR _______________

14. Has the employee returned to partial work? YES □ NO □ If "yes"
    DD ______________ MM ________________ YR _______________

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

____

____

____

____

____

____

16. Was the evidence of the injury obtained YES □ NO □ If "yes", provide detailed list, if "no" seek to obtain

____

____

____

____

____

17. Do you think that at the time of the inquiry that the injured employee was:

- sober? YES □ NO □
- Under the influence of drug? YES □ NO □

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

SECTION D – OCCUPATIONAL DISEASE

1. Date employee notified you of pending claim DD ______________ MM ______________ YR ______________

2. How were you notified? Orally □ Letter □ (attached copy) Writ □ (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 the 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 DD/MM/YR	Wages		Week Ending DD/MM/YR	Wages		Week Ending DD/MM/YR	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			42		
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 TO 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 or any other policy or that any notification has been accepted under the terms of the noted policy or any other policy.

Signature of Employer (If an individual/sole trader)

____

Position/Job Title (if Employer is a Partnership/Company

____

Date ______________________

____

____

FOR OFFICIAL USE ONLY

Continuous period, from ____________________________ to ___________________________ being _____________________ days

Wages earned during this Period ____

$ ___________________________ Monthly Wages

$ ___________________________ Half-monthly compensation from _____________________

$ ___________________________ Compensation from ________________ to ________________ being _________________ days