GK GENERAL INSURANCE COMPANY LIMITED

New Kingston Knutsford Boulevard | Liguanea 124 Hope Road | Mandeville Midway Mall | Montego Bay Fairview Shopping Ctr. | Portmore Portmore Town Ctr.

Toll Free: 1-888-429-5GKG (429-5454) | **Fax:** 876-968-1920 | **Email:** gkginfo@gkco.com | **Website:** www.gkgeneral.com

EMPLOYER'S LIABILITY CLAIM FORM

ACCURACY OF STATEMENTS: *When answering the questions on this form, you must be honest and truthful; if any false or fraudulent statement or declaration is made in support of the claim the Policy shall be rendered void and the claim forfeited.*

THIS FORM SHOULD BE COMPLETED AND RETURNED TO GK INSURANCE WHETHER A CLAIM ON THE INSURED OR NOT

N.B. - The Company does not admit liability by the issue of this Form.

KINDLY COMPLETE IN BLOCK CAPITALS

Claim No: ________________

Policy No: ________________ Date of Policy: ________________________ Date of Last Renewal: ___________________________

POLICYHOLDER TRN ________________________

1. Name (in full): ____

2. Occupation: ____

3. Address: ____

4. E-mail Address: ____

5. In connection with what trade or business did you employ the injured person? ____

____

6. Are you insured elsewhere against this risk? If so, give name of Company: ____

____

PARTICULARS OF INJURED PERSON TRN ________________________

1. Name: ____

2. Date of Birth: ________________________ 3. Married/Single: ___________________________

4. Number of children under 15 years:__________________________

5. Occupation: ____

6. Address: ____

7. Is (s)he related to you? If so, state relationship: ______________-____

8. (a) Is (s)he in your direct employ?________ (b) Is (s)he in your sole employ? _________ (c) Since what date? ___________

9. If in the service of a Sub-Contractor, give the name and address of the Sub-Contractor: ______________________________________

____

THE ACCIDENT

1. State the Date, Hour and Place of Occurrence (a) Date: ____________ (b) Hour: _____________
(c) Place: ____

2. State when Injured Employee ceased work. (a) Date: ____________ (b) Hour: ______________

3. State circumstances in which incident occurred. Provide detailed statement as to how incident occurred on **attached form.**

____

____

4. Were there any witnesses? (Yes/No): ______________

5. If yes state names below and provide detailed statement from witness on the **attached form**

Witness ____________________ ____________________
Name Address

6. (a) Was the employee being supervised at the time. (Yes/No): ______________

(b) If yes, provide statement from supervisor on the **attached form.**

4. State precisely the duties of the Injured Employee when the accident occurred: ______________________

____

5. What was the general nature of the work going on? ____________________________________

____

6. What machinery was in use in connection with the work? ______________________________

7. (a) Give date the injured person first reported the accident: ______________________________

(b) To whom was it reported? ____

8. Did the accident occur during his/her working hours? (Yes/No) ____________________

9. Was (s)he sober? (Yes/No) ________________

10. (a) Was (s)he guilty of any misconduct or disobedience to orders? (Yes/No) ____________

(b) If so, give particulars: ____

____

11. (a) Was the accident due to negligence upon the part of any person? (Yes/No): __________

(b) If so, give name, and state whether such person is in your direct employ: ______________________

THE INJURY - Please enclose medical certificate, if available

1. State very fully the nature and extent of the injury. N.B. - If to a limb, state whether right or left.

2. (a) Is the Injured Employee able to attend to any portion of his work? ______________________

   (b) If so, what is the value of his/her present service?

3. What is the likely duration of incapacity? ______________________

4. Where was (s)he taken after the accident?

5. Where is (s)he now?

6. Name and address of Hospital/ Doctor in attendance

GENERAL INFORMATION

Give details respecting the Accident and the Injured Employee as would be of assistance to the Company. *(Additional information may be provided on the attached sheet)*

What are the wages of the employee?

Weekly ______________________

Monthly ______________________

I/We the undersigned Insured hereby declare that the above statements and facts are true and that it does not contain any false or exaggerated information. I/We have not withheld from the Company any information within my/our knowledge connected with the claim.

Date **Insured's Signature, Stamp & Seal**

STATEMENT OF EMPLOYEE/WITNESS/SUPERVISOR

Please indicate who is completing statement:

Employee □ Witness ☐ Supervisor ☐

Please provide a detailed account of the circumstances in which incident occurred below:

____

____

____

____

____

____

____

____

____

____

____

____

____

____

____

____

____

____

____

I hereby declare that to the best of my knowledge and belief, the above statement is fully and truly made and it does not contain false or exaggerated information.

________________________________ ________________________________

Date **PRINT NAME**