

## EMPLOYER'S LIABILITY CLAIM FORM

The report is made in the bona fide belief that litigation may ensue, and to enable the Company's representatives and Attorneys to conduct such litigation and advise in relation thereto.

### 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. It is necessary therefore, that great care should be taken in completing this form and the information given herein should be strictly accurate, irrespective of whether it is in the Insured's favour or otherwise.

**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

1. Name (in full): \_\_\_\_\_ 2. TRN: \_\_\_\_\_

3. Occupation: \_\_\_\_\_ 4. E-mail Address: \_\_\_\_\_

5. Address: \_\_\_\_\_

6. In connection with what trade or business did you employ the injured person? \_\_\_\_\_

7. Are you insured elsewhere against this risk? If so, give name of Company: \_\_\_\_\_

### PARTICULARS OF INJURED PERSON

1. Name: \_\_\_\_\_ 2. TRN: \_\_\_\_\_

3. Date of Birth: \_\_\_\_\_ 4. Married/Single: \_\_\_\_\_ 5. No. of children under 15: \_\_\_\_\_

6. Occupation: \_\_\_\_\_

7. Address: \_\_\_\_\_

8. Is he/she related to you? If so, state relationship: \_\_\_\_\_

9. (a) Is he/she in your direct employ? \_\_\_\_\_ (b) Is he/she in your sole employ? \_\_\_\_\_ (c) Since what date? \_\_\_\_\_

10. 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.

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4. Were there any witnesses?  Yes  No

5. If yes, 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.

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

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8. What was the general nature of the work going on?

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9. What machinery was in use in connection with the work?

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10. (a) Give date the injured person first reported the accident: \_\_\_\_\_

(b) To whom was it reported? \_\_\_\_\_

11. Did the accident occur during his/her working hours?  Yes  No

12. Was he/she sober?  Yes  No

13. (a) Was he/she guilty of any misconduct or disobedience to orders?  Yes  No

(b) If so, give particulars:

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**⚠ THE ACCIDENT** (CONTINUED)

14. (a) Was the accident due to negligence on the part of any person?  Yes  No

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

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**i 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.

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2. (a) Is the Injured Employee able to attend to any portion of his/her work?  Yes  No

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

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3. What is the likely duration of incapacity?

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4. Where was he/she taken after the accident?

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5. Where is he/she now?

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6. Name and address of Hospital/ Doctor in attendance

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**i GENERAL INFORMATION**

1. 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)

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2. 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: \_\_\_\_\_

## DATA PROTECTION

This is an important notice which outlines how we will collect and process your personal data relating to your claim. You should read it before submitting any personal data to us. To read our full Privacy Notice, visit <https://gk-insurance.com/wp-content/uploads/2024/04/GKGI-General-Privacy-Notice.pdf> or you can request a copy from us.

If you have any further queries about how we use your personal data, please feel free to contact us.

I/ We \_\_\_\_\_ acknowledge and confirm that:

1. I/We have read and understood the Privacy Notice provided to me/us and that I/We are duly authorized to sign this form on behalf of the Insured.
2. I/We consent to GKGI collecting and processing my/our personal data herein to fulfil its contractual obligations under the insurance policy, claim management and comply with legal and regulatory requirements.
3. Sensitive personal data particularly in relation to your medical information, claim history and/or criminal history will be collected herein and I/we acknowledge that the said sensitive personal data collected will be subject to further processing in connection with our insurance claim.
4. To verify the answers provided by me/us in this claim form, GKGI will be sharing and/or seeking information from third parties including but not limited to other insurers, claim service providers, finance companies, databases and/or other regulatory or law enforcement bodies.
5. I/We will be conducting business with GKGI electronically which includes but is not limited to receiving updates, sending and receiving all documents, communications, notices and all other correspondence electronically.

## MARKETING

We would like to send to you, from time to time, information about our other insurance products and services, exclusive offers, promotions, discounts and new products or services. We may also share your personal data with the other subsidiaries with the GraceKennedy Financial Group or GraceKennedy Limited (referred to herein as GraceKennedy Group) and/or its subsidiaries and any other entity that may become part of the GraceKennedy Group.

**Please tick the box(es) below to confirm:**

- I/We consent to the sharing of relevant personal data with other companies in the GraceKennedy Financial Group or parent company GraceKennedy Limited (referred to herein as GraceKennedy Group) and/or their subsidiaries and any other entity/ies that may become part of the GraceKennedy Group.
- I/We consent to GKGI or other companies within the GraceKennedy Financial Group and GraceKennedy Group contacting me/us directly regarding any special offers, discounts, new and existing product offerings and bundles that may be of interest to me/us.

I would like to receive that information by (tick all that apply):

- Email  Text Message  Phone  Post

I/We also understand that I/we may withdraw my/our consent in writing at any time and if I/we choose to withdraw my/our consent, my/our benefits with the GKGI would not be affected.

- I / We declare that the information given in this form is true and correct to the best of my / our knowledge/belief.
- I / We further declare that the statements above can be relied upon in the contemplation of litigation proceedings which may arise.

INSURED'S SIGNATURE:

\_\_\_\_\_ DATE (mm/dd/yyyy): \_\_\_\_\_

INSURED'S SIGNATURE:

\_\_\_\_\_ DATE (mm/dd/yyyy): \_\_\_\_\_

