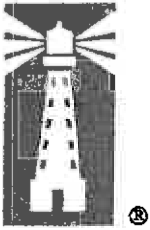

THE BEACON INSURANCE COMPANY LIMITED

HEAD OFFICE:13 Stanmore Avenue,P.O. Box 837, Port of Spain, Trinidad, & Tobago.
Tel: (809) 6-BEACON,625-1113,2640,4746;627-7135,623-9877
Fax: (809) 623-9900

"*The Beacon of Protection*"

REPORT OF ACCIDENT TO WORKMAN

The issue of this form is not to be taken as admission of liability nor answering these questions implies that the injured person is making or will make a claim. Please do not delay despatch of this report, if the information is not readily available. Such particulars may be sent later. All written communication should be forwarded to the Company.

THE EMPLOYER

1. Name of Policyholder	
2. Business / Trade	
3. Address	
4. No. :	
5. Expiry Date :	

THE INJURED PERSON

1. Name	
2. Address	AGE :
3. Name and Address of Parent or Guardian	
4. State occupation in which the injured person is employed	
5. State fully the nature of the work he was doing at the time of the accident	
6. Is the injured person in your direct employ? If not, give name and address of Contractor.	
7. When did the injured person enter your service ?	
8. Name of the Hospital taken to	
9. In-patient or Out-patient ?	
10 Has the injured person been medically examined ? If so, please send report. If not, was free medical examination offered ?	
11. State whether returned to work and, if so, when ? ...	
12. Are you satisfied the injured person has met with a bonafide accident during employment?	
13. Is the injured person able to do partial work ?	
14. What is the probable period of the disablement (approximate) ?	

THE ACCIDENT

1. Date : Time :	Date Work Stopped :
2. Place :	
3. State cause of accident, and if from machinery or gearing : (a) Whether it was fenced or guarded : ... ... (b) Was it being cleaned whilst in motion ?	
4. What protective gear was the injured workman wearing at the time of the accident	
5. What was the general nature of the contract or work going on ?	
6. Brief details of injury	
7. Was the injured person under the influence of drink or drugs at the time of the accident ?	
8. Was he guilty of any misconduct or disobedience to orders or rules? If so, please give full particulars.	
9. State through whose neglect it occurred, if any	
10. State the names of any person(s) who witnessed the accident.	

STATEMENT OF WAGES

The object of this statement is to ascertain the injured person's average monthly earnings. Please therefore observe the following instructions very carefully. Failure to do so will entail unnecessary correspondence and cause undue delay in the settlement of the claim :-

1. If the injured person has been in the Employer's service during a continuous period of more than one (1) month immediately preceding the accident, then the wages that have been paid or fallen due for payment to him in each month of such period (not exceeding twelve (12) preceding months in all), must be entered in the statement.

2. If the injured person has been in the Employer's service for less than one month, then there must be entered in the statement the wages paid **to another workman employed on the same kind of work** by the Employer during the twelve (12) months immediately preceding the accident.

MONTH	WAGES			BONUS, VALUE OF FREE QUARTERS AND ANY OTHER ALLOWANCES, ETC.		
	$	¢		$	¢	
TOTAL :						
	Total including all Allowances -					

(a) Were the above stated wages paid, or fallen due for payment, to the injured person ?
If not, state to whom ....

(b) Was the injured person absent from work at any time, during the above stated period, for fourteen (14) or more consecutive days ?
If so, give the following particulars :-

Absent for .... days from .... to ....

Absent for .... days from .... to ....

Absent for .... days from .... to ....

Absent for .... days from .... to ....

Absent for .... days from .... to ....

I/We hereby declare that the foregoing particulars by me/us are true and correct in every respect.

Date : ....

....
Signature of Employer

Jul96