This Form must be completed by the Employer and returned within Seven Days from ....

Policy .... Agency .... Claim No ....

Gulf Insurance Limited

INCORPORATED IN TRINIDAD, W.I.

Head Office: TRINIDAD, W.I.

PARTICULARS OF ACCIDENT

1.—EMPLOYER'S

Name ....

Business ....

Address ....

2.—Workman's

Name .... Occupation ....

Address ....

3.—State	The age of the Workman	How long he has been in your employ.	His weekly wages at the time of the accident	Whether he is SINGLE, MARRIED, WIDOWER Strike out lines which do not apply.
	..........Years	....	.... See also overleaf	

4.—Was he in your employ and actually doing work for you at the time the accident occurred?
If not, please give the name and address of the person by whom he was employed.

5.—The accident occurred at .... on the .... day of .... 19.....at.....m.
(State the place)
and the disability commenced on the ......day of..................19 ..... at ......m.

6.—When was the accident first reported to you?

7.—Describe (a) what WORK the injured person was doing at the time and (b) how the accident actually occurred. Indicating whether there was any negligence. (Please reply fully).

(a) ....
....

(b) ....
....

8.—State the nature and extent of the injuries.

9.—Has the injured person been treated at a hospital? If so, give dates of admission and discharge ... ...

10.—Give the names of any witnesses of the accident.

11.—Is the workman now doing any work? If so, on what date did he start? ... ...

12.—How much longer is the workman likely to disabled? ... ...

13.—Name and address of doctor in attendance.

14.—What is the motive power of the machinery used on your premises? ... ...

15.—How many employees have you?

Any Correspondence relating to the Accident must be forwarded at once.

I/We hereby declared that the above statements are. to the best of our/my knowledge and belief, true in every respect.

Date ....19 EMPLOYER'S Signature .... **P.T.O.**

A. 22

Gulf Insurance Limited

Claim No. . . . .

STATEMENT OF WAGES PAID TO . . . .

during the 52 weeks, or shorter period of employment, prior to the accident.

Please state the reason for any absense from work, i.e., Sickness, Holidays, etc., when no wages or only part wages are paid in respect of any week or weeks

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