COLONIAL FIRE AND GENERAL INSURANCE COMPANY LIMITED

INJURED WORKMAN - NOTICE FORM

POLICY NO: ..... CLAIM NO:..... CLASS NO:.....

POLICYHOLDER–

1. Name (in full) ... ... 1.....
2. Occupation ... ... 2.....
3. Address ... ... 3.....
4. In connection with what trade or business did you employ the injured person? 4.....
5. Are you insured elsewhere against this risk? If so, give name of Company 5.....

PARTICULARS OF INJURED PERSON–

1. Name..... Date of Birth.....
2. Occupation..... Married or Single.....
3. Address..... Number of children under 15.....
4. Is (s)he related to you? If so, state relationship.....Does (s)he reside with you?.....
5. (a) Is (s)he in your direct employ? 5. (a).....
   (b) Is (s)he in your sole employ (b).....
   (c) Since what date? (c).....
6. If in the service of a Sub-Contractor, give the name and address of the Sub-Contractor. 6.....

THE ACCIDENT–

1. State the Date, Hour, and Place of Occurrence. ... 1. Date.....Hour.....Place.....
2. State when injured Employee ceased work ... ... 2. Date.....Hour.....
3. Describe fully how the accident happened:–.....
4. State precisely the duties of the Injured Employee when the accident occurred 4.....
5. What was the general nature of the work going on? ... 5.....
6. What machinery was in use in connection with the work? 6.....
7. (a) Give date the injured person first reported the accident 7. (a).....
   (b) To whom was it reported? ... ... (b).....
8. Did the accident occur during his/her working hours? 8.....
9. Was (s)he sober? ... ... 9.....
10. (a) Was (s)he guilty of any misconduct or disobedience to orders? 10 (a).....
    (b) If so, give full particulars. (b).....
11. (a) Was the accident due to negligence upon the part of any person? 11. (a).....
    (b) If so, give name, and state whether such person is in your direct employ? (b).....
12. Names and addresses of any witnesses of the accident ... 12.....

THE INJURY–

1. State very fully the nature and extent of the Injury 1.....

N.B.–If to a limb, state whether right or left.

P.T.O.

THE INJURY--*continued*–

2. (a) Is the Injured Employee able to attend to any portion of his/her work?	2. (a).....
(b) If so, what is the value of his/her present services?	(b).....
3. What is the likely duration of incapacity?	3. .....
4. Where was (s)he taken after the accident?	4. .....
5. Where is (s)he now?	5. .....
6. Name and address of Doctor in attendance	6. .....

GENERAL INFORMATION–

Give all such other details respecting the Accident and the the injured Employee as would be of assistance to the Company.

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STATEMENT OF WAGES earned by the injured workman for twelve months prior to the date of the Accident of for such shorter period as he/she may have been in the Employer's service.

NOTE-Please state reason for any period of absence from work, and enclose Medical Certificate.

WEEK ENDED	WAGES		WEEK ENDED	WAGES		WEEK ENDED	WAGES	
			Forward			Forward		
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.....			45.....		
0.....			28.....			46.....		
1.....			29.....			47.....		
2.....			30.....			48.....		
3.....			31.....			49.....		
4.....			32.....			50.....		
5.....			33.....			51.....		
6.....			34.....			52.....		
7.....			35.....			Total Amount earned		
8.....			36.....			in.....weeks $		
Forward			Forward					

Average Weekly Earnings.....

State if any consideration other than cash wages is received by injured person–	
(a) Nature of consideration	(a).....
(b) Cash Value per week	(b).....

I/We the undersigned Policyholder hereby declare that the above statements and facts are true and that I/we have not withheld from he Company any information within my/our knowledge connected with the claim.

Date..... *Signature of Policyholder*.....

(FOR OFFICE USE ONLY)

AVERAGE MONTHLY EARNING – – – – – $.....

RATE OF COMPENSATION PER ½ MONTH – – $.....

Date of Policy..... *Date of Last Renewal*.....