



Middlesea Insurance p.l.c.

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EMPLOYER'S NOTICE OF INJURY REPORT

The issuing of this Form is not an admission of liability by the Company. All questions must be fully answered.

(to be used for claims under Employer's Liability and Group Personal Accident Insurances)

A. EMPLOYER

1. Name of employer _____
2. Address _____

3. Tel No. _____ Telefax No. _____
4. Name of person submitting notice _____

5. Position held by that person _____

6. Policy Number _____
7. Class of Policy _____
8. Please describe nature of the business fully _____

9. VAT Reg. No. _____
10. VAT Status _____
11. Total number of persons employed _____
12. Estimated wage roll for year _____

B. INCIDENT

1. Date and time of incident _____ Location _____
2. When was incident reported? _____ To whom was report made? _____
3. Describe fully the work upon which the injured person was engaged at the time of the incident:

4. Please give a detailed description of the manner in which the injury was sustained _____

5. Please describe and give make/model and age of any machinery involved

6. Please give names and addresses of any witness to the incident and indicate whether they are employees of the insured

C. INJURED PERSON

1. Name _____ Age _____ Usual Occupation _____
2. Home Address _____ Business Address _____

3. How long has he been employed by you _____ Yrs _____ Mths _____ Is he married? _____
4. (a) Gross weekly wage Lm _____ Number of children and ages _____
(b) Weekly wage after tax Lm _____
(c) Weekly N.I. Benefits Lm _____
5. Is he insured elsewhere against accidents? Yes No If so please give name of insurers and policy number _____

D. INJURIES

1. Describe fully the injuries sustained _____
2. Give full details of any injury previously sustained _____
3. Please give the name and the address of the medical practitioner who attended the injured person after the accident _____
4. Is he the injured person's usual medical practitioner? _____
5. Please give details of any medical treatment received by the injured person for illness or accident during the last five years _____
6. As a direct result of this incident has the injured person been totally incapacitated from attending to business of any kind?
Yes No If yes state for how long _____ weeks From _____ To _____
7. Is he still unable to attend to business of any kind? Yes No
If yes please state how long permanent incapacity is likely to last _____
8. Please show the periods for which the injured person was:
(a) Detained in hospital From _____ To _____
(b) Confined to bed at home From _____ To _____
(c) Confined to house From _____ To _____
(d) Able to leave the house From _____ To _____
9. If the injured person is now able to attend to any portion of his business please give details and indicate the date when he started to do so _____
10. Please give the date upon which the injured person returned to full business or employment _____
11. When and where can he be visited by our medical or other officer? _____
12. Has he made a claim against you? Yes No
If yes give full details _____
13. Is he willing to accept an immediate settlement Yes No
14. If yes please state the amount he is willing to accept Lm _____

IMPORTANT NOTE:

Insurers, their Agents and Insurance Associations share information with each other to prevent fraudulent claims and for underwriting purposes. In the event of a claim, some or all of the information you supply on this form and the proposal form together with other information relating to the claim may be provided to other Insurers, their Agents and Insurance Associations.

E. DECLARATION

I/we declare that all particulars given are true and complete and that all communications received relating to this claim will be passed to the Company immediately upon receipt.

SIGNATURE _____

DATE _____

N.B. The attached medical certificate must be completed by the attending medical practitioner in all cases. No claim can be otherwise entertained.