Linkage
Assurance Plc
RC:162306

EMPLOYER'S LIABILITY CLAIM FORM

	THE EMPLOYER	
1	Name of policyholder	
2	Business	
3	Address (and nearest Railway Station)	
4	Policy No.	
	THE INJURED PERSON	
1	Name	
2	Present Address	Age: Sex:
3	Permanent home Address	
4	Name and Address of father	
5	State occupation in which the injured person is employed	
6	Was the injured person engaged in this occupation when the accident occurred? If not, state fully the nature of the work he was doing at the time of the accident.	
7	Is the injured person in your direct entry? If not, give name and address of Contractor	
8	When did the injured person enter your service?	
9	Name of hospital taken to	
10	In or out-patient?	
11	State whether still in hospital or when discharge	
12	Has the injured person been medically examined? If so, please send report, if not, was free medical examination offered?	
13	State whether returned to work and if so, when	
14	Are you satisfied the injured person has met with a bona fide accident of employment?	
15	Is the injured person able to partial work?	
16	What is the probable period of the disablement (approximate)	
	THE ACCIDENT	
1	Date	Time Place
2	Upon what date did you receive notice of accident from? If in writing please attach to this form	
3	On what date did the injured person actually cease work?	
4	State how this accident occurred	
5	If from machinery (a) Whether it was fenced or guarded (b) Was it being cleaned whilst in motion	
6	What was the general nature of the contract or work going on?	
7	State nature of injury	
8	State regions injured	
9	State right or left side	
10	Was the injured person under the influence of drink or drugs at the time of accident?	
11	Was he guilty of any misconduct or disobedience to orders or rules? If so, please give full particulars	
12	State through whose neglect it occurred, if any	
13	State names of any person who witnesses the accident	

The above replies are correct to the best of my/our knowledge and belief

Date: ____________________ Signature: ____________________

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 service during a continuous period (not broken by an absence of 14 or more consecutive days) of 12 months or more, then enter the wages, etc paid to him in each monthly immediately preceding the accident.
2. If he has been in the service during a continuous period of less than 12 months but not more than a month, then enter the wages, etc. paid to him in each month during such period immediately preceding the accident.
3. If he has been in the service during a continuous period of less than one month then enter the wages paid to another workman employed on similar work during 12 months immediately preceding the accident to the workman in respect of whom the claim is being submitted.
4. If you have no workman on similar work and for 12 months then enter the wages etc paid to the insured, the period and the end of the period which should be the date prior to the accident.
5. Please specify the period of which wages have been entered in this statement by mentioning the date of the beginning of the period and the end of the period which should be the date prior to the date of accident.
6. Please do not mention the rate wages. Give full details as above.

MONTH	WAGES		BONUS, VALUE OF FREE QUARTERS & ANY OTHER ALLOWANCE	
	₦	K	₦	K
TOTAL				

Total Including All Allowance

(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 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 ______

Date ______ 20 ______ Signature of the Employer ______

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