

Please print clearly in BLOCK LETTERS throughout. Answer all questions, selecting the necessary check box as appropriate and indicating Not Applicable if required. Date format is DD/MM/YY. This form, together with the Wages Statement overleaf, must be completed and returned to the Company immediately.

Branch/Agent \_\_\_\_\_  
Policy No. \_\_\_\_\_ VAT No. \_\_\_\_\_

**SECTION 1 CLAIM DETAILS**

1. Employer/Insured Name \_\_\_\_\_ Tel No. \_\_\_\_\_  
Email \_\_\_\_\_ Cell No. \_\_\_\_\_  
Business \_\_\_\_\_

2. Date, time and place of accident \_\_\_\_\_  
When was the accident first reported to you and by whom? \_\_\_\_\_  
Names and Contact Details of Witnesses \_\_\_\_\_

3. Name injured person \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Usual occupation \_\_\_\_\_  
Address \_\_\_\_\_  
Where is injured person at present? \_\_\_\_\_  
Does he reside with you?  Yes  No Are you?  Married  Single  Divorced  
Relationship to Employer (if any) \_\_\_\_\_  
When did he enter your service? \_\_\_\_\_  
Is the injured person in your regular employment?  Yes  No  
Indicate if he is:  in your direct employ or  in that of a sub-contractor  
If the latter, state the name and address of the sub-contractor \_\_\_\_\_

4. Noting the definition below, please select which of the following is applicable to you:  
 Politically Exposed Person (PEP)  Related to a Politically Exposed Person (PEP)  Not Applicable

*A **Politically Exposed Person (PEP)** is one who has been entrusted with prominent public functions, for example a head of state or of government, senior politicians, senior government, judicial or military officials, senior executives of state-owned corporations, important political party officials. This category also includes immediate family members close personal and professional associates.*

5. State precisely what he was doing, and how the accident occurred (if the accident was due to any defect in machinery, scaffolding or other equipment, state nature thereof):

Was he performing a duty for which he was employed?  Yes  No Was he disobeying any rule or order?  Yes  No  
Who was in charge? \_\_\_\_\_

Was accident due to another person's negligence?  Yes  No If so, give particulars:

6. Nature and extent of injury. If to arm or hand, state whether right or left.

7. Did he stop work immediately?  Yes  No if No, when did he stop? Date \_\_\_\_\_ Time \_\_\_\_\_  
If taken to a hospital, state which and whether  in-patient or  out-patient \_\_\_\_\_  
Is he disabled now?  Yes  No If No, when did he resume work? \_\_\_\_\_  
What is the probable further duration of disablement? \_\_\_\_\_

8. Is there any other information regarding the accident or the injured person with which the company should be acquainted?

 9. Have you any other insurance or indemnity covering accidents to your employees?  Yes  No If Yes, give particulars:

**SECTION 2 STATEMENT OF EARNINGS**

Statement of the injured person's earnings from me/us during the TWELVE MONTHS PRECEDING THE ACCIDENT, or during the period of his employment, if shorter. If he has been absent from work for any part of the period please enter "nil" in the wages column AND STATE THE REASON.

Week ended		Cash wages	Week ended		Cash wages	Week ended		Cash wages
Month	Day		Month	Day		Month	Day	
1			Bt. FWD	\$			Bt. FWD	\$
2			19				36	
3			20				37	
4			21				38	
5			22				39	
6			23				40	
7			24				41	
8			25				42	
9			26				43	
10			27				44	
11			28				45	
12			29				46	
13			30				47	
14			31				48	
15			32				49	
16			33				50	
17			34				51	
18			35				52	
Carried forward \$			Carried forward \$			Total \$		

State whether there are any other earnings or prerequisites such as board and/or lodging, rent, allowances in kind, etc.

If so, give: (a) Full description \_\_\_\_\_

(b) Estimate of value thereof per annum \$ \_\_\_\_\_

**SECTION 3 DECLARATION**

I/We hereby declare that the foregoing particulars provided by me/us are true and correct to the best of my/our knowledge and belief. I am/we are aware that the failure by me/us to provide information that is true and correct to the best of my/our knowledge and belief, or the withholding of information relevant to this claim may result in CG United Insurance Ltd. denying or voiding this claim, or in criminal prosecution and/or civil proceedings being brought against me/us in accordance with relevant Laws.

Name (if not Insured) \_\_\_\_\_ Title/Position \_\_\_\_\_

Employer's Signature: \_\_\_\_\_ Date \_\_\_\_\_

<b>FOR OFFICE USE ONLY</b>	Total Earnings \$	Average per week \$
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