M & C General Insurance Company Ltd.

Head Office: 9-11 Bridge Street, P. O. Box 99, Castries
St. Lucia, W.I.

EMPLOYER'S NOTICE OF INJURY FORM

This Form must be returned fully completed by Employer to M & C General Insurance Co. Ltd. within 5 days after accident.

Name of Employer:

Address:

Office Use Only

Certificate No………………….
Claim No………………………
Amount of half monthly
Compensation……………….

1. (a) Name of injured person (d) Age
   (b) Address (e) Occupation
   (c) Date of Employment

2. (a) Was the injured person in your employ or employed by a Contractor?
   (b) If latter give name and address of Contractor

3. (a) State time and date of accident
   (b) Describe briefly how accident happened * (see below)

   (c) Was it during the proper performance of his/her work?
   (d) Where did the accident happen?
   (e) Who witnessed the accident?
   (f) When did the workman first notify a responsible official?
   (g) On what date did the injured person cease work?
   (h) State shortly the nature of the injures received and whether the injured person is able to perform any part of his/her duties.
   (i) Is the workman paid daily?
   (j) If workman is other than daily paid workman state date he was last paid wages

   (k) (a) Where is the injured person receiving medical treatement?
   (b) State if admitted to hospital.
   (l) Has the injured person (i) resumed work? If so state date
   (ii) been certified fit by Doctor? If so from what date

- **IF ACCIDENT WAS CAUSED BY (1) WORKMEN'S DISOBEDIENCE OR MISCONDUCT; (2) ANY DEFECT IF EMPLOYER'S BUILDING OR EQUIPMENT; (3) THE FAULT OR NEGLIGENCE OF ANY OTHER PERSON; (4) PRE-EXISTING SICKNESS OR DISEASE OF WORKMAN – GIVE FULL PARTICULARS IN SPACE PROVIDED OVERLEAF.**

I/We certify that the above statement and information supplied overleaf is true and complete to the best of my/our knowledge and belief.

Employer's Signature ……………………………....... Date……………………..

It is necessary that the fullest information should be given in order to avoid delay and the trouble to Insured of subsequence correspondence.

The Company does not admit liability by Issue of this form.

STATEMENT OF INJURED PERSONS CASH EARNINGS

TOTAL OF WEEKLY CASH EARNINGS FOR 52 WEEKS IMMEDIATELY BEFORE ACCIDENT $......................

NB. If injured person has not been continuously employed (no Break of over 14 days) for a full year, start from date of Accident and give weekly wages up to either the date the workman was first employed or to where a clear break of Fourteen days is reached.

If there is no record of the injured person's wages state average estimated weekly wage. If injured person only temporarily employed or only worked very short duration; state average weekly wage of person in similar employment.

SPACE FOR FURTHER PARTICULARS