VANGUARD ASSURANCE COMPANY LIMITED

INSURANCE HOUSE • DERBY AVENUE
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NOTIFICATION OF ACCIDENT FORM - WORKMEN'S COMPENSATION INSURANCE

Answering these questions does not imply that the Employer admits liability, or that the workmen will make a claim.

PARTICULARS OF ACCIDENT

1. Employer's Name _____ Policy No. _____
   Business _____ Phone No. _____
   Address

2. Workman's Name _____ Occupation _____
   Address

3. State the age of the workman How long has been in your employ
   His weekly wages at the time of accident
   His average weekly earnings for the previous 12 months or shorter employ

4. Was he/she in your employ and actually doing work for you at the time the accident occurred? If not, please give the name and address of the person by whom he/she was employed.

5. The accident occurred at on the day of 19
   and the disability commenced on the day of 19 at

6. When was the accident first reported to you?

7. Describe what WORK the injured person was doing at the time and how the accident actually occurred.

8. State the nature and extent of the injuries.

9. State whether employee is left or right handed

10. Has the injured person been treated at a Hospital?
    If so, give date of admission and discharge .....

11. Give the name of any witness of the accident.

12. Is the Workman now doing any work. If so, on what date did he start?

13. How much longer is the Workmann likely to be disabled?

14. Name of Doctor in attendance.

15. What is the motive power of the machinnery used on your premises?

16. How many employees have you?

Signature: _____ Date: _____