

**VANGUARD ASSURANCE COMPANY LIMITED**

INSURANCE HOUSE • DERBY AVENUE  
P.O. Box 1868 • ACCRA  
Tel. (021) 666 485/6 • Fax. (021) 668 610 • Tlx. 2005 VAC GH

**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**

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1. Employer's Name \_\_\_\_\_ Policy No. \_\_\_\_\_  
Business \_\_\_\_\_ Phone No. \_\_\_\_\_  
Address \_\_\_\_\_
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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 \_\_\_\_\_
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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.
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5. The accident occurred at \_\_\_\_\_ on the \_\_\_\_\_ day of \_\_\_\_\_ 19\_\_\_\_  
and the disability commenced on the \_\_\_\_\_ day of \_\_\_\_\_ 19\_\_\_\_ at \_\_\_\_\_
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6. When was the accident first reported to you?
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7. Describe what WORK the injured person was doing at the time and how the accident actually occurred.
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8. State the nature and extent of the injuries.
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9. State whether employee is left or right handed
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10. Has the injured person been treated at a Hospital?  
If so, give date of admission and discharge .....
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11. Give the name of any witness of the accident.
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12. Is the Workman now doing any work. If so, on what date did he start?
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13. How much longer is the Workmann likely to be disabled?

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14. Name of Doctor in attendance.

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

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16. How many employees have you?

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Signature: \_\_\_\_\_

Date: \_\_\_\_\_