

Policy Holder

Name:

Policy No

Tel:

Address:

Email:

Accident to Employee Report Form

This report is made in the bona fide belief that litigation may ensue and to enable the Owners, Representatives, Solicitors, and / or Agents to conduct such litigation and advise in relation thereto.

Name of Insured

Name of Employee:

Address:

Address:

Nature of Business:

Occupation:

Was he in your

direct employ oy:

Policy No:

Phone No.

Details of Accident:

Date:

Time:

Place:

Describe briefly what the employee was doing and how the accident happened -

Nature and degree of injury

Has employee resumed work:

If so, when?

If not, probable duration of incapacity

To whom and when did employee report accident?

WITNESSES. Give Names and Address:

Date Signed.....