



GUARDIAN GENERAL
INSURANCE LIMITED

Head Office: Newtown Centre, 30-36 Maraval Road, Newtown, Port of Spain, Trinidad & Tobago, W.I.
Telephone: (868) 625-GGIL ▪ Fax: (868) 622-9994
Branch Office: 17-19 Independence Avenue, San Fernando, Trinidad & Tobago, W.I.
Telephone: (868) 652-1391 / 4323 ▪ Fax: (868) 652-5228
Website: www.ggil.biz

EMPLOYER’S NOTICE OF A CLAIM MADE BY AN EMPLOYEE

EACH OF THESE QUESTIONS MUST BE ANSWERED COMPLETELY

(Please use block capitals and do not leave blanks or answer a question with a dash)

SECTION A – THE PARTIES

DETAILS OF EMPLOYER	
Policy Number _____	Claim Number _____
Full Name of Employer _____	
Address _____	
Business Activities _____	
DETAILS OF EMPLOYEE	
Name of Employee _____	
Present Address _____	
Previous Address _____	
Date of Birth _____	Date of Joining Company _____
mm/dd/yy	mm/dd/yy
Employee’s present job title _____	
Employee’s present job description _____	
If different from above	
Original job title _____	
Original job description _____	
Is the employee alive or deceased? _____ If “deceased”, date of death _____	
mm/dd/yy	
Is the employee right or left handed? _____	
Is employee in your direct employ? YES <input type="checkbox"/> NO <input type="checkbox"/>	
If “NO” in whose employ? _____	
Relationship of direct employer to you? _____	
DETAILS OF EMPLOYEE’S DEPENDANTS (if any)	
Are there any dependants YES <input type="checkbox"/> NO <input type="checkbox"/>	3. _____ Age _____
1. _____ Age _____	4. _____ Age _____
2. _____ Age _____	5. _____ Age _____
	6. _____ Age _____

SECTION B – USE OF THE FORM (Select the relevant option)

<p>1. The employee named above has been injured in an accident and I/we believe that I/we am/are liable to him/her for Workmen’s Compensation Act injury benefits (Parts II and III of the Act) or at Common Law COMPLETE SECTION C AND SECTION E OF THE FORM</p>
<p>2. The employee named above has made a claim on me/us as his/her employer in respect of an occupational disease (Workmen’s Compensation Act Part IV) COMPLETE SECTION D AND SECTION E OF THE FORM</p>

SECTION C -THE EMPLOYEE HAS SUFFERED OR CLAIMS TO HAVE SUFFERED A SUDDEN INJURY

1. On what date is it alleged that the injury was sustained? _____
mm/dd/yy

2. (a) Describe in detail how the accident occurred _____

(b) State the nature of the injury _____

3. Was the employee instructed to be on location by an official? YES NO
If "YES", by whom? _____

4. Were the activities of the employee supervised? YES NO
If "YES", by whom _____ and give details _____

5. Was First Aid treatment administered? YES NO
If "YES", on _____ by _____ at location _____
mm/dd/yy

6. Was the employee taken to a Medical Facility? YES NO
Name of Medical Facility _____

7. If "YES", was the employee admitted as an "in" or outpatient ?

8. How did you receive the notice of injury/claim? Orally Letter Writ
If "Letter" or "Writ", please attach copy.

9. Location where the incident occurred _____

10. Please give names and addresses of witnesses if possible
1. Name _____ Address _____
2. Name _____ Address _____

11. Date injury was reported _____ 12. Date employee ceased work _____
mm/dd/yy mm/dd/yy

13. Has the injured employee returned to ordinary work? YES NO
If "YES" the work resumption date _____
mm/dd/yy

14. Has the employee returned to partial work? YES NO
If "YES" resumption date _____
mm/dd/yy

15. Were the injuries inflicted by machinery? YES NO
If "YES", list safety procedures _____

16. Was the evidence of the injury retained? YES NO
If "YES" provide detailed list, if "NO", seek to obtain _____

17. Do you think that at the time of the injury, the injured employee was:
Sober? YES NO
Under the influence of drugs? YES NO

18. Was the injured employee negligent? YES NO

SECTION D – OCCUPATIONAL DISEASE

1. Date employee notified you of pending claim _____
mm/ddyy

2. How were you notified? Orally Letter Writ
If "Letter" or "Writ", please attach copy.

3. Is the disease listed in the First Schedule of the Act? YES NO

4. Name of the disease _____

5. Does the employee have a medical report? YES NO
If "YES" attach copy.

6. Describe aspects of present employment that allegedly caused the disease

7. List previous employers, begin with the most recent
(i) _____
(ii) _____
(iii) _____
(iv) _____

SECTION E – THE STATEMENT OF WAGES

STATEMENT OF WAGES earned by _____
Employed by _____ for twelve months prior to the date of the Accident, or for such shorter period as the employee may have been in the Employer's Service.

Week Ending mm/dd/yy	Wages		Week Ending mm/dd/yy	Wages		Week Ending mm/dd/yy	Wages	
1.			19.			37.		
2.			20.			38.		
3.			21.			39.		
4.			22.			40.		
5.			23.			41.		
6.			24.			42.		
7.			25.			43.		
8.			26.			44.		
9.			27.			45.		
10.			28.			46.		
11.			29.			47.		
12.			30.			48.		
13.			31.			49.		
14.			32.			50.		
15.			33.			51.		
16.			34.			52.		
17.			35.			TOTAL (1 – 52)		
18.			36.					

The object of this form is to ascertain the exact average monthly earnings of the injured employee. It is essential that it should be carefully and correctly filled in. If the employee has been absent from work at any time during the period of employment such time must be specified and the reason for absence stated.

I/We certify that all the particulars given on this form are true to the best of my/our belief.

I/We understand that completion of this form does not constitute agreement that any claim is admissible under the noted policy.

Signature of Employer (If an individual/sole trader)

Company Stamp

Position/Job Title (If Employer is a Partnership/Company)

Date _____
mm/dd/yy

FOR OFFICIAL USE ONLY	
Continuous period from _____	to _____ being _____ days
Wages earned during this period _____	
\$ _____	Monthly wages
\$ _____	Half-monthly compensation from _____
\$ _____	Compensation from _____ to _____ being _____ days