STATE INSURANCE
COMPANY LIMITED

Live in a better State of mind

Redcliffe Street P.O. Box 290 St. John's Antigua. W.I.
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WORKMEN'S COMPENSATION
Accident Report

Claim No. _____

Policy No. _____

Employer _____

Address _____

Trade or Business _____

The following information is to be given by the Employer, and full details should be given in order to avoid delay of settlement.

1. Full name of Injured person Full address Occupation Age If married, dependents	(a) _____ (b) _____ (c) _____ (d) _____ (e) _____
2. State fully the nature of the injuries (not if accident resulted from any machinery, state type of machine).	
3. State fully the nature of work insured person was doing at time of accident. Give a through description of how the accident occurred. Was injured person sober at time of accident? In your opinion was the accident attributable to the serious misconduct of the injured person, or negligence of an employee?	(a) _____ (b) _____ (c) _____ (d) _____
4. Date and hour of Accident	
5. Where did the accident occur?	
6. Date of which accident was reported to you and by whom?	
7. Is the injured person receiving medical attention? if so, state name and address of medical doctor, or name and address of hospital or clinic.	
8. Is the injured employee totally disabled? State date injury party ceased work as a result of injury. How long is disablement likely to last? Is the injured person able to attend to any portion of ordinary duties? If so, state what are his services worth to you at the present time.	(a) _____ (b) _____ (c) _____ (d) _____ (e) _____
9. Name and address of any witnesses of the accident.	
10. Is the injured person in your direct and regular employment? If not, give name and address of regular employee. How long has he been continuously employed by you? Has the injured person previously suffered injury giving rise to any disability?	(a) _____ (b) _____ (c) _____ (d) _____
11. Are you insured with any other Company in respect of Liability to Employees? If so, give particulars.	
12. Particulars of the insured person's earning are to be stated overleaf.	
13. Total amount of wages paid to all employees for twelve months to date of last renewal of policy.	

I hereby certify that the information given above is true and correct to the best of my knowledge and belief.

DATE _____ SIGNATURE _____

(PLEASE COMPLETE REVERSE SIDE)

STATEMENT OF INJURED PERSONS EARNINGS

Statement of injures person's weekly cash earnings while in the employment of _____
In each week during the 52 weeks prior to the date of accident or during such shorter period as he may have been employed. If absent from work or time lost, state reason.

WEEK ENDING	WAGES		WEEK ENDING	WAGES		WEEK ENDING	WAGES	
			Brought Forward			Brought Forward		
1			18			35		
2			19			36		
3			20			37		
4			21			38		
5			22			39		
6			23			40		
7			24			41		
8			25			42		
9			26			43		
10			27			44		
11			28			45		
12			29			46		
13			30			47		
14			31			48		
15			32			49		
16			33			50		
17			34			51		
						52		
						Total Wages Earned		
Carried Forward			Carried Forward			In Weeks		

NOTE Fortnightly paid on each two weeks line, monthly pad on each four weeks line.

State the weekly, fortnightly or monthly values of Board and or Lodgings or other allowances (if any) to the Insured Employee.

DATE _____ EMPLOYERS SIGNATURE _____

NOTICE: Policy holders are reminded that the Company cannot accept responsibility for payments made to injured Employees unless authorized by the Company in writing.