JN GENERAL INSURANCE COMPANY LIMITED
Head Office: 9 King Street, Kingston
P.O. Box 395, Kingston, Jamaica, W.I.
Tel: (876) 922-1460, Fax: (876) 922-4045
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OFFICE USE ONLY	
CLAIM NO.	
POLICY NO.	DUE DATE
EMPLOYER	
CODING	

EMPLOYERS LIABILITY NOTICE OF INJURY

NAME OF INSURED_____
_____

To the Policyholder:

Please take great care in completing this form, making sure that you give accurate information even if this does not appear to be in your favour, as the information you give will enable our Solicitators to give you the correct advice and conduct any litigation which may ensue. You should not allow the inspection of any plant or machinery without the consent of the Company (except by the Factory Inspector); neither should you make any payment promise, or offer or admission of liability as this may prejudice settlement.

	DETAILS OF INJURED EMPLOYEE		
1. Full Name			
2. Address			
3. Occupation			
4. (a) Age		4. (b) How long in your service	
5. Was employee engaged at his own job at the time of the occurrence?			
6. Was the employee in your direct service. If not whose?			
7. Present weekly earnings.	$	Date ceased work	Date expected to resume

DETAILS OF ACCIDENT	
8. Date, time and place of accident.	
9. (a) Was the accident caused by machinery? If so, give details of machine. (b) State if machine was properly guarded or fenced.	(a) (b)
10. Was the accident caused by any defect in or unsafe premises equipment or plant. If so, give details	
11. Was the accident caused by: (a) A fellow employee (b) Other person? If so, to whom employed	(a) (b)
12. Was the employee guilty of misconduct Or disobedience of orders? If so, state	
13. Did the employee contribute to the accident? If so, state	
14. By whom was the accident first reported And when?	
15. Give names and addresses of any witnesses.	
16. Please describe the accident fully or give particulars of diesease (use space overleaf if necessary)	

Description of accident contd.

17. Give details of the nature and extent of the Injury i.e. whether fatal, severe or slight and If to limb and /or eye state whether right or Left.	
18. If fatal, where will inquest be held?	
19. Give names and addresses of any hospital or Doctor by whom treatment was given.	
20. Is employee now at home or in hospital? If in hospital state which.	
21. How long is he likely to disabled?	
PARTICULARS OF EMPLOYER	
22. Description of business.	
23. Address of premises or site.	
24. Telephone No.	

I/We declare the foregoing particulars to be true in every respect.

Signed…… Dated.....