

## EMPLOYER'S LIABILITY NOTICE OF INJURY REPORT

### IMPORTANT NOTE

Insurers, their Agents and Insurance Associations share information with each other to prevent fraudulent claims and for underwriting purposes. In the event of a claim, some or all the information you supply on this form and the proposal form together with other information relating to the claim may be provided to other Insurers, their Agents and Insurance Associations.

### ALL RELEVANT QUESTIONS MUST BE FULLY ANSWERED

#### 1. EMPLOYER

Name of Employer	
Address	
Tel/Mob No.	E-Mail
Name of person submitting notice	
Position held by person	
Policy no.	
Please describe fully the nature of the business	
VAT Reg. No.	VAT Status
Total no. of persons employed	Estimated wage roll per year

#### 2. INCIDENT

Date and time of incident	Location
When was incident reported?	To whom was report made?

Describe fully the work upon which the injured person was engaged at the time of the incident

Please describe and give make/model and age of any machinery involved

Please give names and addresses of any witness to the incident and indicate whether they are employees of the insured

### 3. INJURED PERSON

Name		Age
Home Address		
Business Address		
Usual Occupation		
How long has he/she been employed by you? ____ Years ____ Months	Is he/she married? Yes <input type="checkbox"/> No <input type="checkbox"/>	Number of children and ages
Gross weekly wage € ____	Weekly wage after tax € ____	Weekly NI Benefits € ____
Is he/she insured elsewhere against accidents? Yes <input type="checkbox"/> No <input type="checkbox"/>		
If so, please give details of insurers and policy number :		

### 4. INJURIES

Describe fully the injuries sustained

Give full details of any injury sustained previously

Give the name and the address of the medical practitioner who attended the injured person after the accident

Is he/she the injured person's medical practitioner?    Yes     No

Please give details of any medical treatment received by the injured person for illness or accident during the last five years

As a direct result of this incident has the injured person been totally incapacitated from attending to business of any kind?    Yes     No

If yes, state for how long: \_\_\_\_\_ Weeks    From: \_\_\_\_\_  
To: \_\_\_\_\_

Is he/she still unable to attend business of any kind?    Yes     No

If yes, state how long incapacity is likely to last?

Please indicate the periods during which the injured person was:

- Detained in hospital    From \_\_\_\_\_ To \_\_\_\_\_
- Confined to bed at home    From \_\_\_\_\_ To \_\_\_\_\_
- Confined to house    From \_\_\_\_\_ To \_\_\_\_\_
- Able to leave house    From \_\_\_\_\_ To \_\_\_\_\_

If the injured person is now able to attend to any portion of his/her business, give details and indicate the date when he/she started to do so

Give date upon which the injured person returned to full business or employment

When and where can he/she be visited by our medical or other officer?

Has he/she made a claim against you?    Yes     No

If yes, give full details

Is he/she willing to accept an immediate settlement?    Yes     No

If yes, state the amount he/she is willing to accept    €

## DATA PROTECTION AND PROFESSIONAL SECRECY

I consent (on my behalf and on behalf of any other person /s specified in this form (Others) to the processing of any information by the Company or any other members of the Middlesea Group of Companies (the Group) supplied by myself on my own behalf and on behalf of Others, which constitutes personal data as long as this processing relates to administering my insurance proposal and policy, underwriting, handling and settling of claims, detecting, preventing and suppressing fraud and the keeping of statistics.

I understand (and I have explained to the Others) that the Company or any other members of the Group may, in addition, exchange some or all of the information with my insurance intermediary, appointed experts, other insurance companies or the Malta Insurance Association for the above purposes. I also authorise (on my own behalf and on behalf of Others) insurance companies and intermediaries to disclose information about or relevant to my insurance history for these purposes.

I understand (and I have explained to Others) that when I tell the Company about an incident which may or may not give rise to a claim, the Company may pass information relating to it to the Malta Insurance Association and/or other insurance companies or intermediaries.

I authorize (on my own behalf and on behalf of Others) the Company and other companies within the Group to keep me informed of their products and services by mail, fax, email or other electronic means. I understand (and I have explained to Others) that I may inform them in writing if I do not wish to receive this information.

I understand (and I have explained to Others) that I have the right to request access to and rectification of my personal data held by members of the Group by directing my request to Middlesea Insurance p.l.c.

Signature of claimant

## DECLARATION

I/We hereby declare that the above information and statements are, to the best of my/our knowledge and belief, correct and complete. If the answers to all or any of the above questions have been written by others at my/our dictation or instruction I/We confirm that I/We have read those answers and that they are correct and that such person completing this form on my/our dictation or instruction for this purpose will be regarded as my/our agent.

Signature of claimant

Date