

EMPLOYER LIABILITY ACCIDENT FORM

This form must be completed by the policy holder and not by the injured employee. No inspection of any plant premises, of machinery other than the government officials should be permitted without the consent of the insurer. Any evidence, or equipment which may be useful in asserting liability, should be carefully preserved. Any third party correspondence received should be forwarded to us immediately.

Please Complete, Sign and return to your O'Leary contact as soon as possible

1. EMPLOYER

Name of Employer: _____ Insurer + Policy Number: _____
 Address: _____ Date of Payment of Last Premium: ___/___/___ (DD/MM/20YY)
 _____ VATRegistered: Yes No
 Business: _____ Telephone Number: _____

2. INJURED PERSON

Name of Injured Person: _____ Married Single Age _____
 Address: _____ Occupation: _____
 _____ RSI No: _____

State whether the injured person was in your direct employment or in the service of another employer? _____

Was the injured person's employment casual or regular

If casual, state how often employed and last period commenced? _____

If regular, how long has he/she been employed by you prior to the accident? _____

Did the employee undergo a Medical Examination on joining your firm? Yes No If so by whom? _____

Has the employee, to your knowledge, been involved in any previous accidents, in the course of his employment or outside his employment? If so please give detail _____

3. PARTICULARS OF ACCIDENT

State the date and time of accident: ___/___/20___ Time: ___ am pm State the name of place where accident occurred: _____

State the date on which the injured person ceased work: ___/___/___ State the date on which the accident was reported Date: ___/___/___

On what work was the employee engaged at the time of the accident? _____

Was the accident sustained: while the employee was working on machinery? Yes No If so, specify the type of machine _____

Was the employee performing part of his/her duties at the time? Yes No

As a result of the negligence of a fellow employee Yes No

As a result of any defect in the premises? Yes No

Detail: _____ Detail: _____

Was the injured employee guilty of any misconduct or disobedience of orders? If so give particulars: _____

Furnish names, occupations and addresses of witnesses of the accident: _____ Furnish any further information in your possession bearing on accident: _____

4. INJURIES SUSTAINED

State fully the nature and extent of injuries: _____

Was the employee taken to hospital? Yes No

Which Hospital: _____

If taken to hospital, as an in patient or as an out patient

Discharge Date: ___/___/___

If taken home, give the name and address of the doctor attending: _____

Is the employee being paid while absent from work? Yes No If so, how much and for how long will this payment continue? _____

State how many employees are in your service: _____ The amount of annual cash wages paid to them: _____

