THE INSURANCE COMPANY OF THE WEST INDIES LIMITED
21 King George V Street, Roseau, Dominica Tel: (767) 440-ICWI (4294)

EMPLOYERS NOTICE OF INJURY FORM

This Form should be returned, fully completed by Employer, within 48 hours after the accident.

I hereby declare that all particulars to be given are true and correct and that no false or fraudulent statement will be made _____
Insured's Signature

NOTE: "N/A" means "Not Applicable"

Policy No.

Name of Employer _____

Address _____

Business or Occupation _____

Email Address _____

1. Name of Injured _____ Date of Birth _____
2. Address _____
3. Date Employment Commenced _____ Occupation _____
4. Was the injured Person in your direct employ? If not, please give name and address of Employer.

   _____

   _____
5. Please state: (1) Date: _____ (2) Time: _____ (3) Place of Accident: _____
6. Have you received a formal notice of the accident. If so: (1) When: _____ (2) In what form: _____
7. Describe briefly how accident happened (see below): _____

   _____

   _____
8. If machinery was involved: (1) Was it being used? _____ (2) Was a guard provided? _____
9. Was it during the proper performance of his/her work? _____
10. Who witnessed the accident? _____
11. Did the injured person cease work? If yes, on what date. _____
12. State briefly the nature of the injuries received and whether the injured person is able to perform any part of his/her duty.

    _____

    _____

    _____
13. Probable period of disablement: _____
14. Is the employee paid: (1) Daily or otherwise: _____ (2) When was he last paid _____
15. Where is the injured person receiving medical treatment? Please state if admitted to hospital. _____

    _____
16. Has the injured person: (1) Resumed work (If so, please state) _____

    _____

    (2) Been certified fit by doctor (If so, please give date)

IF THE ACCIDENT WAS CAUSED BY :
(1) Workman's disobedience or misconduct
(2) Workman being under the influence or drink or drugs, or breaking any rule or order
(3) Any defect in employers building or equipment
(4) The fault or negligence of any other person
(5) Pre-existing sickness or disease of workman
Please give full particulars in space provided on overleaf.

I/We certify that the above statement and information supplied on the overleaf is true and complete to the best of my/our knowledge and belief.

Employer's Signature: _____ Date: _____

To avoid delay, please ensure that information given is full and complete.

THE INSURERS DO NOT ADMIT LIABILITY BY THE ISSUE OF THIS FORM.

STATEMENT OF THE INJURED PERSON'S WEEKLY CASH EARNINGS

(For 52 Weeks Immediately before accident)

N.B.
IF INJURED PERSON HAS NOT BEEN CONTINUOUSLY (NO BREAK OVER 14 DAYS) EMPLOYED FOR A FULL YEAR, START FROM DATE OF ACCIDENT AND GIVE WEEKLY WAGES UP TO EITHER THE DATE THE WORKMAN WAS FIRST EMPLOYED OR TO WHERE A CLEAR BREAK OF FOURTEEN (14) DAYS IS REACHED.

IF THERE IS NO RECORD OF INJURED PERSON'S WAGES STATE AVERAGE ESTIMATED WEEKLY WAGE IF INJURED PERSON ONLY TEMPORARILY EMPLOYED OR ONLY WORKED VERY SHORT DURATION STATE AVERAGE WEEKLY WAGE OF PERSON IN SIMILAR EMPLOYMENT.

Week Ending (Date)	**Wages**		**Week Ending (Date)**	**Wages**		**Week Ending (Date)**	**Wages**	
1.			Forward			Forward		
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.		
18.			35.			52.		
Forward			Forward			Total		

MONTHLY AVERAGE: _____ WEEKLY COMPENSATION: _____

CLAIM SETTLED FOR: _____ PERIOD OF INCAPACITY: _____

PAID ON: _____

PLACE FOR FURTHER PARTICULARS