Notification of Injury to an Employee



LIFE INVESTMENTS HEALTH INSURANCE PROPERTIES ADVICE

Liberty General Insurance Uganda Limited 3rd Floor, 99 Buganda Road P.O. Box 22938 Kampala, Uganda t + 256 (0) 31 2246500

This form is to be filled up and sent to the Company immediately the accident comes to the Employer's knowledge.

WORKMEN'S COMPENSATION

The Employer's attention is specially drawn to the fact that his interests are identical with those of the Company, in as much as the future rates of premium for insurance will naturally depend upon the amount paid by the Company in claims. It is essential therefore that everything possible should be done to prevent any but bona fide claims being admitted to benefit under the Policy.

Policy number														C	laim	num	ber													
EMPLOYER DETAILS																														
Name of Employer																														
Address																														
Policy number														Date	e of la	ast pa	aymer	t of p	orem	ium	D	D	-	М	М	-	Υ	Υ	Υ	Υ
Name of trade or business																														
INJURED EMPLOYEE DETAILS																														
Name of employee																													T	$\overline{}$
Address																													Ť	司
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Occupation	Marital status Married								ried			Single	e																	
Is the injured Employee related to the Employer? Yes N									lo																					
If so, what is the relationship?																														
Was the Injured Workman in the employ of the in	surec	d or of	f a Co	ntrac	tor?		Ye	S		Ν	Ю																			
If YES, name of contractor																														
Address of contractor																														
Nature of contract																														
Was the Injured Workman's employment casual o	r regi	ular?			Cas	ual			Reg	ular																				
If the casual, state how often employed																														
If the regular, state how long he had been employ	ed by	y you	or su	ch Co	ntrac	tor p	rior to	the	accid	ent																				
Give rate of pay including allowances at the time of the Accident. (State whether per day, week or month)																														
If apprentice, learner or improved, state his terms of remuneration to end of apprenticeship and how much he might then expect to earn																														
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																														-
State fully the nature of the work he was doing at	the t	ime c	of the	Accio	lent																									
																														_

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How did the Accident occur?																															
	_																														
Where did the accident occur?																															
When did the accident occur?	D	D	-	М	М	-	Υ	Υ	Υ	Υ																Ti	me				
How long has the claimant been awarded?					ı		1	1					7			_			_						_						
Off duty days	From	1	D	D	-	М	М	-	Υ	Υ	Υ	Υ	То	D	D		- 1	Л	M	-	Υ	Υ	Υ	/ \							
Light duty days	From	1	D	D	-	М	М	-	Υ	Υ	Υ	Υ	То	D	D) -	.	Л	М	-	Υ	Υ	Υ	/ \							
When did the workman resume full duties	D	D	-	М	М	-	Υ	Υ	Υ	Υ																Ti	me [
Give names and address of witnesses of the accid	dent																														
NAME									AD	DRE	SS																				
Was the Accident caused by			1		-	1	CI			C 1 1					/			NI-		A	ء ـ د		r	-1-1				\/-			
Violation of rules		es]		0]	Carel	essne	ess o	rınjur	ea Er	прюу	/ee?	Y	'es			No		АПУ	aere	ect o	тпа	chine	ery or	гріа	nt? [Ye	.5	l l'	No
If so, had such been brought to your notice?		es		N	0				1			1																			
Was the injured person sober at the time of the a	ccider	nt?					Y	es		1	No.																				
Under whose direction was he at the time of accident?																															
Was the accident caused by carrying out such dire	ection	1?					Y	es		1	No																				
Was the injured person suffering at the time of the Accident from ill-health or bodily defect or infirmity of any description																															
									1			1																			
Were you aware of such ill-health, defect or infirm	nity?						Y	es		1	No																				
Has the injured person previously received comp			or an			7					ur se	rvice	or in 1	that c									tate	2							
Date of the accident	D	D	-	М	М	-	Υ	Υ	Υ	Υ					Am	ount	of co	omp	ensa	tion	rece	ived									
State as fully as possible the nature of the injuries	recei	ved																													
			.1						6 11																						
State to what extent the injured person is disable	a, and	3 WN6	etner	adsoli	utely	prev	entec	Trom	1 TOIIC	wing	nis e	mpio <u>'</u>	ymer	IT.																	
State what you consider will be the probable dura	ation (of tot	tal dis	ablem	nent.																										
,																															
NOTE: It is important that the fullest possible info	ormat	tion t	oe giv	en un	der t	his he	ead.																								
Name of injured workman's Medical Attendant																															
Address of injured workman's Medical Attendant																															
																Ī		Ī					Ī		T	Ī	Ī				$\overline{\square}$
If in Hospital, name of Medical Attendant														l				Ť					Ť		İ						$\overline{\Box}$
Date the injury was first attended to by a Doctor?	D	D] -	М	М	-	Υ	Υ	Υ	Υ		1	1	1									-			Ti	me [

Have you received notification of a Magisterial Enquiry, or of intention to institute any legal proceedings : Yes No																				
If YES, give full particulars																				
I/We hereby certify that the above Statement is with the claim.	a full and true account	to the be	st of my/o	ur knowle	edge and l	belief, an	d I/We u	ndertal	ke to adv	rise the	e Com	pany p	oromp	tly of a	all deve	:lopme	ents ir	ı conn	ectio	n
Employer's Signature											Date	D	D	- [M M] -	Υ	Υ	Υ	Υ
Notice to Employer: It is a condition of your Po Company	licy that no payment m	iust be m	ade, nor an	ıy liability	admitted	, in respe	ect of Ac	cidenta	l Injury to	o an Er	mploy	ee, un	til orde	ered b	y the C	ourt, c	or autl	horise	d by 1	the
Certificate to be filled up and Signed by an Ey	ye Witness, if possible	by the p	erson und	der whos	e directi	on the V	/orkma	n was a	t the tin	ne of t	he Ad	ciden	t.							
I hereby certify that I was present when the acci	ident occurred to																			
Date accident occurred	D D - M	- M	YY	YY																
The accident happened in the following manner	-																			
Occupation																				
Signature of Insured (If a Limited Company give status of signatory)											Date	D	D	- [M M	7 -	Υ	Y	Υ	Υ
(i) a Emmed Company give status of signatory)																_		-		