Tatil
... where people are people

Trinidad and Tobago Insurance Limited
11A Maraval Road,
Port of Spain,
Trinidad and Tobago, W.I.
P.O. Box 1004
Tel: (868) 62-TATIL (82845)
Email: info@tatil.co.tt
Web: www.tatil.co.tt

FOR OFFICIAL USE ONLY
Policy Number: _____
Producer Name: _____
Producer Number: _____
Branch: _____
Claim Number: _____

WORKMEN'S COMPENSATION ACCIDENT REPORT FORM

Please give complete answers to all questions

THE INSURED

1. Name	Email Address:
2. Postal Address	Telephone:
3. Business Address	Telephone:
4. Give a full description of the trade or business carried out at the premises	

THE INJURED PERSON

5. Name	Date of Birth:
6. Postal Address	Telephone:
7. Occupation	Date Employed:
8. Is the Insured Person married or single?	Number children 18 years or under:
9. What is the Injured Person's relationship to the Insured?	Does s(he) reside with you?
10. Was (s)he in your direct employ? If NO, give details of Employment.	

THE ACCIDENT

11. Date of Occurrence	Time:
12. Place of Occurrence	
13. What was the general nature of the work going on at the time of accident?	
14. State precisely the duties of the Injured Person at the time of accident.	
15. Were these the normal duties (s)he is employed to perform?	
16. Did the accident occur during his/her working hours?	
17. Was (s)he in the course of employment at the time of the accident?	
18. Was (s)he sober at the time of the accident?	
19. Was (s)he guilty of any misconduct or disregard of any procedures or orders?	

20. Was the accident due to the fault on the part of any person? If YES, state the name and address.

Name	
Address	

21. State the name and position of the person to whom the accident was first reported. — Date Reported:

Name	
Position	

22. State the names and addresses of any witnesses.

Witness	Address

23. Describe fully how the accident occurred.

THE INJURY

24. Nature and extent of the injury sustained. State the severity, regions and side of body involved.	
25. Is the Injured Person able to satisfactorily complete any part of his/her work?	If YES, what part or percent?
26. When did the Injured Person cease work?	What is the likely period of incapacity?
27. Do you think the injury will result in permanent disability?	Is (s)he right or left handed?
28. Where was (s)he taken after the accident?	
29. Where is (s)he now?	
30. State the name and address of the attending Physician?	

STATEMENT OF WAGES earned for twelve months prior to the date of the accident, or for such shorter period as (s)he may have been in the insured's service.

WEEK ENDING	WAGES $	c	WEEK ENDING	WAGES $	c	WEEK ENDING	WAGES $	c
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**		

Declaration

Please confirm by selecting this box your declaration as follows:

☐ I/WE DECLARE THAT THE ABOVE STATEMENTS AND FACTS ARE TRUE AND THAT I/WE HAVE NOT WITHHELD ANY INFORMATION WITHIN MY/OUR KNOWLEDGE CONNECTED WITH THE CLAIM.

SIGNATURE OF INSURED _____ **DATE** _____