Trinidad and Tobago Insurance Limited
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WORKMEN'S COMPENSATION
ACCIDENT REPORT FORM

(Please give complete answers to all questions)

FOR OFFICIAL USE ONLY

Policy Number: .....
Producer Name: .....
Producer Number: .....
Branch: .....
Claim Number: .....

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?** ☐ Yes ☐ No
10. **Was "(s)he" in your direct employ?** ☐ Yes ☐ No

    If **"No"**, give details of Employment: .....

THE ACCIDENT

11. **Date of the accident:** ..... **Time:** .....
12. **Place where the accident occurred:** .....
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?** ☐ Yes ☐ No

    If **"No"**, give details: .....
16. **Did the accident occur during his/her working hours?** ☐ Yes ☐ No

    If **"No"**, give details: .....
17. **Was (s)he in the course of employment at the time of the accident?** ☐ Yes ☐ No

    If **"No"**, give details: .....
18. **Was (s)he sober at the time of the accident?** ☐ Yes ☐ No

    If **"No"**, give details: .....
19. **Was (s)he guilty of any misconduct or disregard of any procedures or orders?** ☐ Yes ☐ No

    If **"Yes"**, give details: .....
20. **Was the accident due to the fault on the part of any person?** ☐ Yes ☐ No

    If **"Yes"**, state: Name: .....

    Address: .....
21. **State the name and position of the person to whom the accident was first reported.**

    Name: .....

    Position: ..... Date Reported: .....
22. **State the names and addresses of any witnesses.**

Name of 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? ☐ Yes ☐ No

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? ☐ Yes ☐ No Is "**(s)he**" right or left handed? .....

28. Where was "(s)he" taken after the accident? .....

29. Where is "(s)he" now? .....

30. Attending Physician's Name: ..... **Physician's Address:** .....

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 ($)	WEEK ENDING	WAGES ($)	WEEK ENDING	WAGES ($)
1		FORWARD	0.00	FORWARD	0.00
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	0.00	FORWARD	0.00	TOTAL	0.00

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: .....

Signature of Driver: ..... Date: .....

THE COMPANY DOES NOT ADMIT ANY LIABILITY BY THE USE OF THIS FORM.