



The Tatil Group
 TRINIDAD AND TOBAGO INSURANCE LIMITED
 TATIL LIFE ASSURANCE LIMITED

11 Maraval Road, Port of Spain, Trinidad and Tobago, W.I. P.O. Box 1004
 Tel: (868) 628-2845 or (868) 622-5351-8
 Fax: (868) 628-6545 or (868) 628-0035

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 Full Description of 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: _____ am/pm
12. Place of Occurrence	
13. What was the general nature of the work going on at time of accident?	
14. State precisely the duties of the Injured Person at 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 fault on the part of any person? If YES, state name and address.	
21. State name and position of person to whom the accident first reported.	Date Reported:
22. State the names and addresses of any witnesses.	

23. Describe fully how the accident occurred.

24. Nature and extent of injury sustained. State 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 Name and Address of 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		WEEK ENDING	WAGES		WEEK ENDING	WAGES	
	\$	c		\$	c		\$	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		

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** _____