

Claim Form

Employer's Liability

Please answer all of the following questions as fully as possible. Where there is insufficient space, use a separate sheet of paper.

Claim No.
 (for use by the Company only)

The Insured			
Policy No.	Renewal Date		
Full Name	Telephone		
Address	Employer's Social Insurance No.		
Type of Business / Service	Total Amount of salaries and benefits		
Number of Employees			per week/ per month

The Injured			
Name	Date of Birth		
Home Address	Home Tel. Number		
Weekly earnings on the day of the accident	ID Number		
Date of recruitment to the company	Occupation/ Specialty		

Details of Injuries
Describe the injuries sustained by your employee and attach the relevant certificates.
Please state the name of the hospital or clinic where the injured person was hospitalised
Address of hospital/clinic
Number of days that they stayed in the hospital or clinic
When according to the doctors opinion will he/she return to work?

The Accident

Date Time

Location

Eyewitnesses

Name

Address

Name

Address

Did they at the time of the injury, perform part of his/ her usual duties?

YES / NO

If no, who instructed them to perform the work in which they were injured?

Was the employee working on a machine at the time of the accident?

YES / NO

If yes, please indicate the type and make of machine

Was the accident due to a technical defect in the building / machine / tools used?

YES / NO

If yes, please provide details

Was the accident due to another person's negligence?

YES / NO

Has he/she shown negligence or did not obey your injured person's instructions to be responsible for himself / herself for the accident?

YES / NO

If yes, please state why they are responsible

Have you reported the accident to the Ministry of Labour?

YES / NO

If no, state the reasons why

Describe in detail how the accident occurred

Employer's Remarks / Comments

Taking into account the circumstances under which the accident occurred, do you consider that you have any responsibility as an employer and why?

Who gave instructions and defined the manner in which the injured carried out his work?

Declaration

I declare the foregoing particulars to be true in every respect, and I hereby assign to Commercial General Insurance Ltd (CGI), in accordance with the terms of the Policy, the handling of all claims and litigation arising out of this accident and to which the Policy applies. I further authorise CGI to initiate all necessary legal measures and/or settle any claim which is deemed reasonable without any further notice to me. I further undertake to give all such information and assistance as CGI may require.

I agree to provide CGI with data and information that may be used as necessary proof for the examination of my claim by CGI and/or any third party that CGI cooperates with. The personal data collected by CGI is completely relevant and necessary for the purpose of assessing my claim under the terms of my insurance policy, subject to the provisions of the General Data Protection Regulation (GDPR) and any related legislation. Furthermore, I acknowledge CGI's right to share my personal data with any third parties to the extent required for the performance of a contract, due to legal obligations and legitimate interest, considering that CGI has taken all appropriate measures to ensure that such third parties follow the guidelines of the GDPR regarding the safe processing of personal data.

I understand that in the event where I require further information as to the way CGI processes personal data, I may contact CGI's Data Protection Officer at 101 Arch. Makarios III Avenue, 1071, Nicosia or through email at DPO@cgi.com.cy or refer to CGI's Privacy Notice which is available at <http://www.cgi.com.cy>.

I further authorise any authorities such as the Police and/or other institutions or insurance companies to provide full information on the facts of this claim to CGI when such a request is made by CGI for the purpose of assessing my claim.

Signature of Employer _____ Date _____

Signature of Injured Employee _____ Date _____