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Employer's Liability Notice of Injury Report

IMPORTANT NOTES

Insurers, their Agents and Insurance Associations share information with each other to prevent fraudulent claims and for underwriting purposes. In the event of a claim, some or all the information you supply on this form and the proposal form together with other information relating to the claim may be provided to other Insurers, their Agents and Insurance Associations.

ALL RELEVANT QUESTIONS MUST BE FULLY ANSWERED

1. EMPLOYER DETAILS

Name of Employer:	
Address:	
Tel/Mob No.:	Email:
Name of person submitting notice:	
Position held by person:	
Policy no.:	
VAT Reg. No.:	VAT status:
Total no. of persons employed:	Estimated wage roll per year:

2. INCIDENT DETAILS

Date and time of incident:	Location:
When was incident reported?	To whom was report made?
Please give a detailed description of the manner in which the injury was sustained:	
Describe fully the work upon which the injured person was engaged at the time of the incident:	
Please describe and give make/model and age of any machinery involved:	
Please give names and addresses of any witness to the incident and indicate whether they are employees of the insured:	

3. INJURED PERSON

Name:	Age:	
Home Address:		
Business Address:		
Usual Occupation:		
How long has he/she been employed by you? Years Months	Martial status of injured person: Single ☐ Married ☐ Seperated ☐ Divorced ☐ If married, is spouse in full time employment: Yes ☐ No ☐	Number of children and ages:
Gross weekly wage €	Weekly wage after tax €	Weekly NI Benefits €
Is he/she insured elsewhere against accidents? YES ☐ | NO ☐		
If so, please give details of insurers and policy number:		

4. INJURIES

Describe fully the injuries sustained:
Give full details of any injury sustained previously:
Give the name and the address of the medical practitioner who attended the injured person after the accident:
Is he/she the injured person's medical practitioner? YES ☐ | NO ☐
Please give details of any medical treatment received by the injured person for illness or accident during the last five years:
As a direct result of this incident has the injured person been totally incapacitated from attending to business of any kind? YES ☐ | NO ☐ If yes, state for how long: Weeks From: To:
Is he/she still unable to attend business of any kind? YES ☐ | NO ☐
If yes, state how long incapacity is likely to last?
Please indicate the periods during which the injured person was:

Detained in hospital	From	To
Confined to bed at home	From	To
Confined to house	From	To
Able to leave house	From	To

If the injured person is now able to attend to any portion of his/her business, give details and indicate the date when he/she started to do so:

Give date upon which the injured person returned to full business or employment:
When and where can he/she be visited by our medical or other officer?
Has he/she made a claim against you? YES ☐ | NO ☐ If yes, give full details:
Is he/she willing to accept an immediate settlement? YES ☐ | NO ☐
If yes, state the amount he/she is willing to accept: €

NB The attached medical certificate must be completed by the attending medical practitioner in all cases. No claim can otherwise be entertained.

PERSONAL DATA PROCESSING

If you would like to know more about how Mapfre Malta p.l.c. processes your personal data, please refer to the following link: www.mapfre.com.mt/privacy-policy/.

DECLARATION

I/we hereby declare that, after checking all details, the above information and statements are, to the best of my/our knowledge and belief, correct and complete. I/we understand that in the event of an incomplete and/or non-disclosure of material information, Mapfre Malta p.l.c reserves the right to repudiate the claim. Furthermore, I/we declare that I/we have not withheld any information relevant to the claim and assume full responsibility for the statements being made.

If the answers to all or any of the above questions have been written by others at my/our dictation or instruction I/we confirm that I/we have read those answers and that they are correct and that such person completing this form on my/our dictation or instruction for this purpose will be regarded as my/our agent.

Date:
Insured's signature(s):