Elmo Insurance Ltd
Head Office: Abate Rigord Street, Ta' Xbiex, XBX 1111, Malta.
Tel: 234 30000 (General) 21 345037 (Fax)

Employers' Liability Claim Form

With reference to your recent notification of an accident to an employee, please complete and return this form to the address shown above as soon as possible.

It is to be completed by the Employer and not handed to the Employee.

If any communication relating to this accident is received from or on behalf of the injured employee, please pass it to us unacknowledged without delay.

No payment or promise of payment should be made and liability should not be admitted without our authority.

Preliminary particulars of accident

1 Insured

Policy No.

Name

Address

Postcode

Business | Tel. No.

E-mail

Name of Company Doctor | Tel. No.

2 Employee

Full Name | I.D. No.

Address

Postcode

Occupation | Married/Single | Age

Is he in your direct employ and receiving wages from you? Yes No | National Insurance No.

If not, state whether

a) working as own master? Yes No | b) employed by a contractor? Yes No

How long has he been employed by you? | E.T.C. Number

Name and address of previous employer

What were his average weekly earnings during the 13 weeks preceding the accident?

a) Gross Euro | b) Net (i.e. after deduction of Income Tax and National Insurance Contribution) Euro

3 Accident (if disease, complete section 6)

Date | Time am/pm

Place

Particulars of work upon which the employee was engaged at the time

Was he performing part of his duties? Yes No

Did the accident occur while employee was working with machinery? Yes No

If with machinery, state type of machine and the maker's description, model and year of make

Is the machinery your own property? Yes No

If not, to whom does it belong?

Did the accident occur as a result of

a) any defect in the premises, equipment or plant? Yes No

b) the negligence of a fellow employee? Yes No

c) any misconduct or disobedience of orders on the part of the employee? Yes No

How did the accident occur?

Please carefully preserve any broken parts of machinery, plant, equipment, or tool involved in the accident

4 Notification and Witness

To whom was the accident first reported and when?

If not reported, give explanation

Was entry made in accident book? Yes ☐ No ☐

Give name, address and occupation of any person who witnessed the accident

If the accident was not witnessed, give reasons (if any) for supposing it arose out of an in the course of employment

Extract of Entry in Accident Book

Name of Injured person

Address

Occupation

Name of person making entry

Occupation

Date of Accident

Time am/pm

Date entry made

Place where accident happened

Cause and nature of injury

5 Injuries

What injury did the employee sustain?

When did he cease work?

Did he receive medical attention? Yes ☐ No ☐

If so, from whom?

Is he detained in hospital? Yes ☐ No ☐

If so, give name of hospital?

Is he totally disable? Yes ☐ No ☐

How long is he likely to be totally disabled?

If he has returned to work give date of return

State whether he has resumed light or full duties

6 Disease (alternative to section 3)

State nature of disease

To what is it attributed i.e.. nature of substance, material or irritant?

Was he asked if he had ever suffered from this complaint on entering your employ? Yes ☐ No ☐

Has he had any previous attacks while in your employ? Yes ☐ No ☐

Date on which you were notified of the disease

Date on which the employee ceased work

What is the nature of the work on which he engaged?

For what period has he been so engaged?

Has he received treatment for the disease on your premises? Yes ☐ No ☐

Have any other employees suffered from the same disease during the past 3 years? Yes ☐ No ☐

Are there special precautions taken at your premises to prevent this particular disease? Yes ☐ No ☐

If so, give details

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7 Claim

Has any claim been made by or on behalf of the injured employee? Yes ☐ No ☐

If so, give date of claim, by whom made and whether written or verbal

(All correspondence received should be forwarded with this form)

Data Protection Notice

I consent to the processing of my personal data by Elmo Insurance supplied by myself as long as this processing relates to administering my employers liability insurance policy, underwriting, handling and settling of claims, detecting, preventing and suppressing of fraud and the keeping of statistics. I authorize Elmo Insurance to seek any medical information relating to myself or any person with whom I am travelling. I also authorize any doctor, hospital, laboratory or other insurance provider to provide full information concerning myself or any person with whom I am travelling. I understand that Elmo Insurance may, in addition, exchange information with others (including the Malta Insurance Association or other insurance companies) for the prevention of fraud. I authorize Elmo Insurance to keep me informed of its products and services by mail, fax, email or other electronic means. I understand that I may inform Elmo Insurance in writing if I do not wish to receive this information. I also understand that I have the right to request access to my personal data by contacting Elmo Insurance in writing.

Deceleration

I declare that, to the best of my knowledge and belief, the statements and information given are true. I give my consent to Elmo Insurance to obtain any report and to contact any person or organization involved in my claim. I understand that by consenting, I am permitting Elmo Insurance to use this information in the form together with any extra information gathered during the claims process for the purposes of processing the claim or for other purposes permitted by law. I also agree to provide Elmo Insurance Ltd. with the necessary document they may need in order to be able to process my claim. I understand that without this consent Elmo Insurance may not be able to process this claim.

I also agree that a copy of this content shall have the validity of the original claim form.

Signature

Date