

# EMPLOYERS' LIABILITY ACCIDENT CLAIM FORM

Branch/Broker/TII:

Policy No:

Return this form together with respective documents (payslips/FS3/medical certificate/NI30) to: - GasamMamo Insurance, Msida Road, Gzira GZR 1405 Malta. For any queries please call 2134 5123 ext 5.

## INSURED'S DETAILS

Name:

ID No:

Address:

Tel No / Mob No:

Contact Person:

Company Reg No:

VAT No:

Email:

Occupation / Nature of Business:

Business Address:

## SECTION 1

Name of injured person:

National Insurance No:

ID No:

Age:

Married / Single:

Does the spouse work on a full time basis? Yes

No

Address:

Occupation:

Contact No:

Name & Address of family doctor:  
\_\_\_\_\_  
\_\_\_\_\_

**SECTION 2**

Where is the injured person at present?  
\_\_\_\_\_  
\_\_\_\_\_

Date of Employment:        /        /

Is the injured person in your regular employment?  
\_\_\_\_\_  
\_\_\_\_\_

**SECTION 3**

Date, time and place of accident:  
\_\_\_\_\_  
\_\_\_\_\_

Describe how the accident occurred.  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Was he/she performing a duty for which he/she was employed?     Yes     No

Was he/she disobeying any safety or company rules or orders?  
\_\_\_\_\_  
\_\_\_\_\_

Who was in charge?

Was the accident due to another person's negligence? If so, please give details.

Name & Address of witnesses of the accident:

#### SECTION 4

Nature & Extent of Injury. (If to eye or limb, please state whether right or left.)

Did he/she stop working immediately?

If not, when did he/she stop?

If taken to hospital, please state which and whether in-patient or out-patient.

Date when he/she is expected to resume work:    /    /

Is there any other information regarding the accident or the injured person with which the company should be acquainted?

## SECTION 5

Do you have any other Insurance or indemnity covering accidents to your employees?

If yes, please give details.

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## SECTION 6

Weekly/Monthly Gross Earning: (please attach relevant FS3/FS4 or pay slip)

Amount of Injury Leave Benefit received/due:

Does the injured person work a 5 or 6 day week?

## DOCUMENTS

Please mark and attach with this claim form the following documents:

- National Insurance Injury Certificate (NI 30)**
- Manager's Report of Accident**
- Medical Certificates**
- Evidence of Gross Earnings**

## DIRECT CREDIT DETAILS

Kindly complete your bank details below if you would like to receive payment of your claim directly into your bank account. We can only make SEPA payment.

### Account holder details

Name:  ID No:

Address:

Town:  Mob No:

Email:

### Bank account details

Name of Bank:  Country:

IBAN No:

## DATA PROTECTION NOTICE

To the extent that the information supplied by you, whether orally or in writing, constitutes personal data, including sensitive data within the provisions of the Data Protection Act, you consent to the processing of such data for purposes of administering your proposal for insurance, your Policy, underwriting, handling of claims and also for the purposes of detecting, preventing and suppressing fraud and of keeping statistics. We may be required to collect further information from our sub-agents, other insurance companies, insurance intermediaries or insurance associations.

In addition, we may pass some or all of the information to other insurance companies, or insurance associations for underwriting and claims handling purposes and also for the purposes of detecting, preventing and suppressing fraud and of keeping statistics. This also helps us to check the information provided. When we deal with your request for insurance, we may search this information. When you tell us about an incident which may or may not give rise to a claim, we will pass information relating to it to the Malta Insurance Association.

We and other companies within our group would like, on occasion, to keep you informed of our products and services, by mail, fax, e-mail or other electronic means. Please inform us in writing if you do not wish to receive this information or if you wish to receive such information solely from GasanMamo Insurance Ltd. Moreover, we hereby ask you whether you wish to receive direct marketing information from us by e-mail to your e-mail address provided above.

You have the right to request access to, and rectification of, your personal data held by us by directing your request in writing signed by yourself to the Data Protection Officer, GasanMamo Insurance Ltd, Msida Road, Gzira GZR 1405.

## DECLARATION

I/We declare that the statements made are true to the best of my/our knowledge and belief and fully agree with the above and hereby consent to the above treatment of my personal data.

Date:

Full name in block letters:

Signature of policyholder: