



Employers Liability Insurance Claim Form

PLEASE COMPLETE IN FULL ALL SECTIONS OF THIS CLAIM FORM AS SOON AS POSSIBLE AFTER THE ACCIDENT AND SUBMIT TO SACOS ALL THE REQUIRED DOCUMENTS

IMPORTANT INFORMATION

1. All statements must be factual, not influenced or biased in any form.
2. Please provide Sacos with as much information about the accident as you can.
3. The list of documents required is not exhaustive and we reserve the right to request from you any additional information/documentation as and when necessary.
4. The submission of an incomplete form, insufficient information or supporting documents may delay the processing of your claim.

1. INSURED DETAILS

POLICY NUMBER

Name

Postal Address

Occupation

Telephone (Mobile)

Telephone (Work)

Email Address

THE PERSON SUBMITTING THIS FORM (IF DIFFERENT FROM POLICYHOLDER)

Name

Postal Address

Telephone (Mobile)

Telephone (Work)

Email Address

2. ACCIDENT DETAILS

Date of occurrence (dd/mm/yyyy)

Time of occurrence (am/pm)

Place or Address of Occurrence

Please provide a full description of how the accident occurred

You may include a separate list if there is insufficient space provided above.

State precisely the duties of the injured employee when the accident occurred

Date that the accident was reported (dd/mm/yyyy)

To whom was the accident reported to?

Did the accident occur during the employee's working hours? Yes No

Was the employee guilty of any misconduct or disobedience to orders? Yes No

If selected Yes, please provide details

Was the accident due to the negligence upon the part of any other (Indicate answer with tick below)

Employees Non-Employees

If selected any of the above, please provide details to justify your answer and provide the name (s) of employees or Non-employees.

3. PERSONAL INJURIES OR DEATH DETAILS

Names and addresses of persons injured/died and particulars of injuries sustained

A Name

Address

Contact number

Age

Occupation

Monthly Salary

Please attach a copy of latest pay slips

Date Employed (dd/mm/yyyy)

Is the worker in your direct employ?

Is the worker in your sole employ?

Is the worker covered by any medical scheme?

Name and addresses of hospital/clinic at which injured person have been treated

Nature of Injuries

Note: Please attach a copy of medical report, sick leave certificate and death certificate incase of death

B Name

Address

Contact number

Age

Occupation

Monthly Salary

Please attach a copy of latest pay slips

Date Employed (dd/mm/yyyy)

Is the worker in your direct employ?

Is the worker in your sole employ?

Is the worker covered by any medical scheme?

Name and addresses of hospital/clinic at which injured person have been treated

Nature of Injuries

Note: Please attach a copy of medical report, sick leave certificate and death certificate incase of death

C Name

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Address

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Contact number

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Age

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Occupation

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Monthly Salary

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Please attach a copy of latest pay slips

Date Employed (dd/mm/yyyy)

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Is the worker in your direct employ?

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Is the worker in your sole employ?

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Is the worker covered by any medical scheme?

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Name and addresses of hospital/clinic at which injured person have been treated

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Nature of Injuries

Note: Please attach a copy of medical report, sick leave certificate and death certificate incase of death

Has a claim been made upon you? Yes No

If yes, give full particulars and amount and forward any communications received, unanswered

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Note: (Please do not accept liability or attempt to negotiate with anyone)

Have you in any way admitted liability? Yes No

In your opinion who was negligent?

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4. WITNESSES

Name and addresses of all witnesses

A Name

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Address

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Contact Number

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B Name

Address

Contact Number

I hereby declare that to the best of my knowledge and belief the statements and particulars contained herein are truthfully made and that i have not withheld any material fact concerning the accident.

Signature of Insured or his/her broker or legal representative

Date and Time

LIST OF DOCUMENTS REQUIRED FOR CLAIM SETTLEMENT *(To be submitted to the Sacos office)*

- Duly filled and signed claim form
- Medical Report/Medical Note
- Sick Leave Certificate (s)
- Death Certificate (Incase of Death)
- Certified True copy of coroner's/post mortem/autopsy report (Incase Accidental Death)
- Statement from the Injured person
- Statement from Witnesses (Optional)
- Police Report/Road traffic accident report (If applicable)
- Pay Slip (s)
- Copy of Gainful Occupational Permit (GOP) for foreigners.