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Lasaco
Assurance Plc
Reg No. 31126

EMPLOYERS' LIABILITY CLAIM FORM

POLICY NO_____

Employer: _____

Address: _____

Trade or Business _____ Usual number of Employees _____

The following information is to be furnished by the Employer, and full details should be given in order to avoid delay and the trouble to policy holders of subsequent correspondence.

1. (a) (i) Full Name of injured person, and (ii) Age	(a) (i) (ii)
(b) Full Address_____	(b)
(c) Occupation _____	(c)
(d) If married, and number of dependants if any___	(d)
(e) Is the Injured person related to you?_____	(e)
(f) On what date was the injured person first engaged by you? _____	(f)
(g) Has the injured person been previously involved in any accident? If so, please give details	(g)
2. State fully the nature of the Injuries _____ (NOTE – If accident happened in connection with any machinery, kindly state the type of machinery involved).	
3. (a) State fully the work upon which the injured person was engaged at the time of the accident	(a)
(b) Describe fully how the accident happened_____	(b)
(c) Was the Injured person sober at time of accident?__	(c)
(d) In your opinion was the accident attributable to the serious and willful misconduct of the injured person or to the negligence of any person whosoever?_____	(d)
(e) Give the name and grade of person in charge	(e)

DATA PROTECTION NOTICE AND CONSENT

Lasaco Assurance Plc is data protection regulation compliant. All information submitted by you will be processed and managed in line with the Nigeria data protection regulation.

_____
Sign

4. Date and hour of accident _____	Date Hour
5. Where did the accident occur? _____	
6. Date on which accident was reported to you and by whom ___	
7. Is the Injured person receiving medical attention? If so, state name and address of medical attendant or name and address of Institution and whether inpatient or outpatient _____	
8. (a) Is the Injured employee totally disabled? _____	(a)
(b) State the date the Injured person ceased to work on account of the injury _____	(b)
(c) How long is disablement likely to last? _____	(c)
(d) Is the Injured person able to attend any portion of ordinary duties? _____	(d)
(e) If so, state what his services are worth to you at the present time _____	(e)
(f) Has the injured person made any claim on you? _____	(f)
9. Names and address of any witness of the accident	
10. (a) Is the Injured person in your direct and regular employment? _____	(a)
(b) If not, give name and address of the regular Employer	(b)
(c) How long has he been continuously employed by you? _____	(c)
11. Are you Insured with any other Company in respect of liability to Employees? If so, give particulars_____	
12. Particular of the injured person's earnings require to be stated below _____	
13. Total amount of wages paid to all employees for twelve months to date of the last renewal of policy___	₦

(Please complete the statement below)

STATEMENT OF INJURED PERSON'S EARNINGS

Statement of injured person's Monthly cash earnings while in the employment of

…… **in each Month during the** 12 *months prior to the date of accident*

or during such shorter period as he may have been employed. If absent from work or time lost, state reason

_____

Month Ending	WAGES	Month Ending	WAGES	Month Ending	WAGES
		Brought forward		Brought forward	
1		5		9	
2		6		10	
3		7		11	
4		8		12	
Carried forward		Carried forward		Total wages earned In …….. Month ₦	

State the Monthly value of board and/or lodgings or other perquisites (if any) allowed to the injured employee: ₦

I hereby certify that the information given above is true and correct to the best of my knowledge and belief

Date …… *Employer's Signature* ……

IMPORTANT: - Policy holders are reminded that the Company cannot accept responsibility for payments made to injured employees unless authorized by the Company in writing.