Sagicor

# PERSONAL ACCIDENT
## Employer's Statement

### Employee Details

_____ Full Name of Insured

_____ Policy Number(s)

Name of Workplace _____

Address of Workplace _____

_____

_____

State Insured's Full Earnings $_____ per week $_____ per month

### If Claim is for Injury

Where did it occur? _____
_____
_____
_____

How did it occur? _____
_____
_____
_____

When did it occur? _____
_____
_____
_____

### If Claim is for Illness

Describe the illness _____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

### Dates

State the exact date the Insured
Gave up his duties _____ Returned to Work _____

Length of disability _____ days

During the period was the Insured entitled to any remuneration or benefits from the employer? Give Details

_____

_____

State any period of time the Insured was able to perform only part of his duties

From _____ To _____

### Signatures

| _____ | _____ | _____ |
|---|---|---|
| **Signature of Employer** | **Dated** | **Official Title & Company Stamp** |

**Remarks**