



GOLDMAN INSURANCE LIMITED

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EMPLOYERS LIABILITY CLAIM FORM

THE ISSUE OF THIS FORM IS NOT TO BE TAKEN AS AN ADMISSION OF LIABILITY

1. Important Instructions

- a. Claim form is to be filled in capital letters and signed by the insured.
- b. Please answer all the questions on this form. If a question does not apply to your claim, please answer "N/A".
- c. We recommend that you read the Claims section of your policy.

1. INSURED.....ADDRESS.....
.....TEL No.
POLICY No.....AGENT:
NAME OF INJURED PERSON:
ADDRESS:
OCCUPATION:

2. DETAILS OF INJURED EMPLOYEE

- (a) Name of Injured or deceased person:
- (b) Address:
- (c) Marital Status: (d) Age:
- (d) Occupation: (e) How long in Service:

3. INJURY DETAILS

- (a) Date & Time of Accident:
- (b) Place or Location:
- (c) What was the employee doing:
- (c) Was the employee performing his/her ordinary duties:
- (d) Was he/she in your direct service:
- (e) How did the accident occur:
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- (f) What were the nature of the employee's injuries:
 - (g) Were there any witnesses:
 - (h) Was the accident reported to the police:
 - (i) If yes name the police station and date reported:
 - (j) Have you received notice of a claim:
 - (k) Have you admitted liability :
 - (l) Do you think you are legally liable:
 - (m) Was the injured person taken to hospital:
 - (n) If so which hospital:
 - (o) Has the employee returned to work, if yes when:

4. Any Other Information considered pertinent:

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I/We hereby declare the above to be true and correct to the best of my/our knowledge and belief.

DATE: SIGNATURE OF INSURED.....