



EMPLOYERS LIABILITY CLAIM FORM

KBL Insurance (Company does not admit liability by the issuance of this form)

- 1. Policy Number.....
- 2. Name of Insured.....
- 3. Address of the insured.....
- 4. Name of contact.....
- 5. E-mail Address.....
- 6. Mobil Number.....
- 7. Name of employee.....
- 8. Occupation.....
- 9. Employees Address & Mobile Number.....
- 10. Period of Cover.....
- 11. Is the employee in your direct employ?.....
- 12. If not employed by you give details of employer.....
- 13. What injuries did the employee sustain?.....
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- 14. Date and time of accidentPlace.....
- 15. Where was the employee treated?.....
- 16. Was the employee admitted in the hospital?.....
- 17. If yes please provide Name, Address & Contact of Hospital.....
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- 18. Was the accident reported to Police?.....if yes provide report
- 19. Please give details of any payment made since the incident and provide evidence.....

Declaration

I.....do hereby declare that the information given above is true and correct to the best of my knowledge.

Signature.....Date.....

Witness

Name.....Address.....

Signature.....Date.....