LORDS INSURANCE
Guarding Your Tomorrow.

WORKER'S COMPENSATION CLAIM FORM

Name of Employer_____

1. Address of Employer_____
2. Injured Person(s) Name_____

_____

3. Injured Person(s) Job Title (description usual duties)_____

_____

4. Date of accident_____
5. Where did the accident occur?_____
6. Date and to whom accident was reported?_____
7. a) At what time did the accident occur?_____

   b) Was the Injured Person(s) acting in the course of his employment at the time of the accident?_____
8. How did the accident occur?_____

_____

_____

9. Statement from witness(es) (attach separate sheet if necessary)

_____

_____

_____

_____

10. Nature of injury (note that forms BL43/02, BL43/03, BL43/04B & BL43/10 must accompany this claim form)

_____

11. Steps taken to prevent a re-occurrence_____

_____

Thereby warrant the truth of the above statements

Signature of Manager on behalf of Employer_____

Name of Company_____Date_____