فيدلتي المتحدة
Fidelity United

EMPLOYER'S LIABILITY - CLAIM FORM

IMPORTANT NOTES:

Issuance of this form is not an admission of liability. The claim shall be assessed strictly based on policy terms and conditions. All questions must be answered fully.

PART: (A) POLICY HOLDER:

Name of insured **Policy No:**

Address **Business/Occupation**

Telephone/Mobile /Fax

PART :(B) OCCURRENCE:

Date and time of incident.

Place /location where the incident occurred.

Date reported and to whom?

Describe fully how the accident occurred and what the injured person was doing at the time.
(*Please attach extra sheet if below space is not sufficient*)

Gross weekly wage of the person

UNITED FIDELITY INSURANCE COMPANY
In Conformity with the Federal Law No. 6/2007 Reg. No (8) dated 22/12/1984. Authorized paid-up Capital Dh. 100,000,000

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Names and addresses of any witnesses.

DESCRIPTION OF WORK ON WHICH INJURED PERSON WAS ENGAGED.

What injuries have been sustained?

Have you had an injury of the same nature before? **YES** ☐ **NO** ☐

Has the injured person received proper training or instruction as to how to perform the work? **YES** ☐ **NO** ☐

Whether the injured person was wearing the safety gear, helmet or protective clothing? **YES** ☐ **NO** ☐

Was the insured person aware of the dangers whilst exposed to the type of work he was performing?
YES ☐ **NO** ☐

Was the injury suffered due to a fellow employee's fault or negligence? **YES** ☐ **NO** ☐

Was the injured person exposed to exceptional danger as perceived by the Employers? **YES** ☐ **NO** ☐

If **YES,** was the work undertaken under proper supervision and control? **YES** ☐ **NO** ☐

If machinery was involved, please give details of make, type etc.

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State:

What injuries have been sustained?

Whether injured person has ever had an injury to the same part before YES ☐ NO ☐

Is the injured person insured elsewhere against accidents? **YES** ☐ **NO** ☐ IF YES, give particulars.

Is the injured person suffering from any disease in addition to the present injuries, or has he any physical defect?
YES ☐ **NO** ☐ If **YES**,state the nature of same and to what extent the recovery may be effected thereby.

During what period was the person totally disabled from attending to any art of his occupation/profession?
From ☐ To ☐

If recovered, please state date of recovery ☐

***If total disablement continues, please attach completed certificate by the injured person's doctor. ***

DECLARATION:

I/We declare that all particulars given are true and complete and claim the sum of Aed. _____ as detailed above as supported by the enclosed documentary evidence.

Signature: ☐ **Date** ☐

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