



**FIRST ASSURANCE COMPANY LTD**

- **HEAD OFFICE** - First Assurance House, Clyde Gardens, Gitanga Road, Lavington, P O Box 30064-00100, Nairobi, Kenya  
Tel: 254-020-2900 000 Cell: 0722-444117/0733-605480 Fax: 2900 200 Email: [hoinfo@firstassurance.co.ke](mailto:hoinfo@firstassurance.co.ke), [www.firstassurance.co.ke](http://www.firstassurance.co.ke)
- **MOMBASA BRANCH** - First Assurance House, Nyali Road, Off Mombasa-Malindi Road, P O Box 43559, Mombasa, Kenya  
Tel: 254-041-4476494/4476495, Fax: 254-041-4476495 Email: [msainfo@firstassurance.co.ke](mailto:msainfo@firstassurance.co.ke)

**EMPLOYER'S NOTICE OF INJURY FORM**

1. This form, fully completed, must be returned without delay, and within seven days at least, so that the Company may be fully in a position to decide as to the admission or non-admission of liability for the accident in the event of the injured person making a claim.
2. Policyholders are reminded that the company cannot hold itself responsible for payments made to injured employees without its authority.
3. The Employer's attention is particularly drawn to the fact that his interests and those of the Company are identical, in as much as the future premiums payable naturally depend upon the amount of claims paid by the company. He should therefore do everything possible to prevent any but bona fide claims admitted.
4. Before making payments of salary or wages to injured employees details of your liability should be obtained from your labour Officer, and from us.
5. If, in your opinion, the accident was caused as a result of the employee's serious and wilful misconduct, the labour officer and we must be supplied with details.
6. Please attach a copy of the advice of accident, from which you have completed for the labour officer. Return of the claim form should not, however, be held up on that account.
7. The insured is requested to consult with the company before committing himself to any payment to the insured employee.

**THE EMPLOYER**

Name of Employer \_\_\_\_\_

Policy No. \_\_\_\_\_

Postal Address \_\_\_\_\_ Postal Code \_\_\_\_\_

Trade or business \_\_\_\_\_

Telephone No. \_\_\_\_\_

Date of Payment of last premium \_\_\_\_\_ To whom paid \_\_\_\_\_

**PARTICULARS OF THE INJURED EMPLOYEE**

Name of Injured Person \_\_\_\_\_

Residence \_\_\_\_\_ Age last Birthday \_\_\_\_\_ (Years)

What is his/her occupation (describe fully)? \_\_\_\_\_

Where can he/she be seen at present? \_\_\_\_\_

Is he/she Married, Single, a Widower or Widow? \_\_\_\_\_



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Has he any children (please give details) \_\_\_\_\_

Earnings at time of accident:

Cash \_\_\_\_\_ Food \_\_\_\_\_

Fuel \_\_\_\_\_ (per Month/Week/30)

Quarters \_\_\_\_\_ (day ticket)

Bonus/ Regular Overtime \_\_\_\_\_

If on hourly basis show rate and number of hours per month \_\_\_\_\_

If the employment is of a casual nature, state how he/she was being paid and when his/her weekly average with you and other employers would amount to \_\_\_\_\_

Date he/she entered your service \_\_\_\_\_

Was injured person in your direct employment and pay? \_\_\_\_\_

Or in the employ of a contractor to you? \_\_\_\_\_

**THE ACCIDENT**

Describe precisely what the Injured person was doing at the time of the Accident, and how the Accident occurred \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Was the injured person doing the work he/she should been doing and in the way in which it should have been done? \_\_\_\_\_

Describe the nature of the contract or work in progress \_\_\_\_\_

When did the accident occur? On \_\_\_\_\_ the \_\_\_\_\_ day of \_\_\_\_\_

At \_\_\_\_\_ o'clock in the \_\_\_\_\_

Where did the accident occur? \_\_\_\_\_ was he/she sober? \_\_\_\_\_



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Did the injured person notify the accident to you (or to your representative) before he/she voluntary left your service? \_\_\_\_\_

When was the accident first reported to you? \_\_\_\_\_ If not reported to You, to whom was it reported? \_\_\_\_\_

To which labour officer was the accident reported? \_\_\_\_\_

Name and Address of Medical Practitioner who attended \_\_\_\_\_ of \_\_\_\_\_

If the accident is connected with machinery or gearing, was machinery or gearing fenced or guarded? \_\_\_\_\_

Was the accident due to the employee's serious and willful misconduct or that of another person? If so, give details \_\_\_\_\_

Describe fully what the negligence was \_\_\_\_\_

Names and address of persons who witnessed the 1) \_\_\_\_\_

Accident \_\_\_\_\_ 2) \_\_\_\_\_

**THE RESULTS OF THE ACCIDENT**

Describe as well as you can, in ordinary language, the nature of injuries (if to Eye, Arm or Legs, state whether right or (left) \_\_\_\_\_

The Injured Person left off work on the \_\_\_\_\_ day of \_\_\_\_\_ Year \_\_\_\_\_

Is the Injured person confined to bed or house? \_\_\_\_\_

Is the Injured person able to attend to any portion of his/her duties? \_\_\_\_\_

If returned to whole or any part of former work state when \_\_\_\_\_ Year \_\_\_\_\_

If not, when is he/she expected to do so? \_\_\_\_\_ Year \_\_\_\_\_

I/We warrant that the foregoing statement is a true account to the best of my/our knowledge and belief.

Date \_\_\_\_\_ Signature \_\_\_\_\_