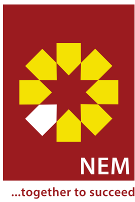

NEM Insurance Plc

199, IKORODU ROAD, OBANIKORO, LAGOS
PO Box 654 Marina Tel: 01-448956-09; 01 4489570
Email: nem@nem-insurance.com; Claims@nem-insurance.com

EMPLOYERS LIABILITY CLAIM FORM

IMPORTANT
*** This form should be filled in by the person named as the 'Insured' on the policy schedule.**
*** Form is to be filled in CAPITAL LETTER and signed by the Insured. All asterisked (*) items must be filled to completion**
*** The issue of this form does not imply admission of liability**

Policy Number ....

Period of Cover: From .... To ....

1 INSURED DETAILS*

Name of Insured ....

Address ....

....

Phone .... Email: ....

We can send you alerts for any update on your claim. Please confirm how you would prefer to receive your alert

Email ☐ SMS ☐ Both ☐

2 DETAILS OF LOSS* *(The following information is to be provided by the Employer, and full details should be given to avoid delay)*

1) a) Name, Age and Address of Injured Party ....

....

b) State Injured Party's average monthly earnings (SEE OVERLEAF) ....

c) Indicate Occupation in which he/she is employed ....

d) Is the Injured Party in your direct employment, if so specify date of employment ....

e) Is the injured person single, married or widowed? ....

f) State number of Children and their age(s) ....

g) Has the injured party been previously involved in any accident? If so, provide details ....

....

2) a) Please state the full nature of the injuries sustained *(If incident occurred in connection with any machinery, provide details of machinery involved)* ....

....

b) Provide name and position of Person-in-charge ....

....

....

....

3) a) Accident Date .... Time .... am ☐ .... pm ☐

b) Where did the Accident occur? ....

c) Date on which Accident was reported to you and by whom? ....

d) Indicate the Date the Injured Party stopped work ....

e) State fully the work upon which the injured party was engaged at the time of the incident ....

....

f) Describe how the accident occurred? ....

g) At the time of the accident, was the Injured party sober or intoxicated? ....

4) a) Is the Injured Party receiving medical attention? Yes ☐ No ☐

b) If YES above, specify name and address of hospital ....

....

5) a) Name and Address of Doctor in attendance? ....

....

6) a) Is the Injured Party totally disabled? Yes ☐ No ☐

b) State Date the Injured Party stopped working as a result of the Injury sustained ....

c) How long is disablement likely to last? ....

d) Is the Injured Party able to carry out any part of his duties? Yes ☐ No ☐

e) If YES, state what his services are presently worth ....

f) Has the Injured Party made any Claim on you? Yes ☐ No ☐

7) a) Name and Address of Witness of the accident ....

Name .... Address ....

....

....

....

8) Please provide name, address and policy number of any Insurers concerned with this accident. ....

....

....

....

....

....

....

....

3 STATEMENT OF INJURIED PARTY'S EARNINGS

THE WORKMAN'S COMPENSATION ORDINANCE PROVIDES FOR COMPENSATION BASED ON THE WORKMAN'S AVERAGE MONTHLY EARNING DURING THE PAST 12 MONTHS OR SUCH SHORT PERIOD AS HE MAY HAVE BEEN IN THE EMPLOYER'S SERVICE.

PLEASE GIVE PARTICULARS AS UNDER WITH REASONS AS FAR AS KNOWN FOR ANY TIME "ABSENT"

Month Ending	WAGES & BONUS	Month Ending	WAGES & BONUS	Month Ending	WAGES & BONUS
		Brought forward		Brought forward	
1		5		9	
2		6		10	
3		7		11	
4		8		12	
Carried forward (N)		Carried forward (N)		Total Wages earned	

State the Monthly value of any allowances i.e. Food, Fuel, or Housing allowed to the Injured Party: N

4 Data Privacy

i. Your data will solemnly be used for the purposes of this business contract and also to enable us reach you with the updates about our products and services.

ii. Please note that your personal data will be treated with utmost respect and is well secured as required by Nigeria Data Protection Regulations 2019.

iii. Your personal data shall not be shared with or sold to any third-party without your consent unless we are compelled by law or regulator.

5 DECLARATION

1. I/We declare to the best of my/our knowledge and belief that the information given on this form is true in every respect and agree that if I/we have made any false or fraudulent statement, be it suppression or concealment, the policy shall be cancelled and the claim shall be forfeited.
2. I/We agree to provide additional information to **NEM Insurance**, if required.
3. I/We agree to submit all required and requested for documents and **NEM Insurance** shall not be held responsible for any delay in settlement of claim due to non-fulfillment of requirements.

Signature of Policyholder Date

NEM Insurance Plc. reserves the right to refute any fraudulent claims

CLAIMS PROCEDURE (Please read carefully to understand the claim process)

* NEM Insurance should be notified immediately.
* NEM Insurance may ask for additional documents and /or clarification if any, depending on the requirement of the claim.

For claims status enquiries, you may contact us on +234 1 448 9570, +234 7030855602, +234 8035629237

NEM Insurance Plc. is regulated by the National Insurance Commission (NAICOM)