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## **Workmen Compensation Claim Form**

(Please use block capitals and do not leave blanks or answer a question with a dash)

Client Number			AIB Bra	nch F		Policy Number
			INSU	RED INFORMATIO	N	
Name of Incured						
Name of insured		Surname First Name				Middle Name
Address of Insured						
		Street			City	Country
Telephone Number	(868)		(868)_		Email Address	
		Primary		Secondary		
	Street City Country  er (868) (868) Email Address  CLAIM DETAILS INFORMATION  CLAIM DETAILS INFORMATION  / Employee					
Injured Workman/ Er	INSURED INFORMATION  ame of Insured  Surname  Street  City  Country  Elephone Number  (868)  Primary  CLAIM DETAILS INFORMATION  CLAIM DETAILS INFORMATION  Surname  First Name  Middle Name  Amelia Address  Secondary  Time (Hour)  Surname  Surname  First Name  Middle Name  Amelia Accident  Date DD / MM / YYYY  Time (Hour)  Street  City  Country  as the accident caused by negligence? YES □ NO □  The the injuries severe or minor?  The injuries severe or minor?  The injuries sustained  Date DD / MM / YYYY  Signature:  Date DD / MM / YYYY  Date DD / MM / YYYY  Signature:					
		Surname		First Name		Middle Name
Dataila of Assidant						
Details of Accident						
Location of Accident						
		Street			City	Country
Was the accident cau	used by ne	egligence? YES	□ NO □			
Was the accident caused by negligence? YES □ NO □  Are the injuries severe or minor?						
, we the injuries seve.						
State the nature of the injuries sustained						
Has the injured workman/employee returned to work? YES $\square$ NO $\square$						
If yes please state da	ata ha/sha	returned to wo	rk			
Signature:						
Prii	nt Name				Signature	
Date:						