Workers’ Compensation Claim Form

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Use of this form is not to be taken as an admission of liability.

Claim form to be filled out and signed by the Insured (employer). Answers to all questions are required and a medical certificate signed by the attending Physician is necessary for all claims which involve loss of wages. When complete, please send this form via email to submitclaim@bfm.bm, or fax it to 295-8647, or return it by hand to BF&M’s main office in the Insurance Building on Pitts Bay Road, Pembroke.

1. Insured (employer)

Full name	Contact person
Business address	
Work phone	Home phone
Mobile phone	Email

2. Injured person (employee)

Full name	Date of birth (DD/MM/YY)
Home address	
Occupation	
Is the injured person employed directly by the employer? ☐ Yes ☐ No	If yes, for how long

3. Accident details

Date of accident	Time ☐ am ☐ pm	Date reported to employer
Location		
Give a full description of the accident, and any machinery involved		
Did the accident arise out of and in the course of the employment of the employee by the employer? ☐ Yes ☐ No		

4. Witnesses

Provide information of witnesses to the accident. Please enclose their statement(s), if available

	Name	Email address	Phone number(s)
1			
2			
3			

5. Injuries

Please describe the nature and extent of injury sustained by the employee			
Name of attending Physician		**Was the employee hospitalized?**	☐ Yes ☐ No
Hospital admission date (DD/MM/YY)		**Hospital discharge date (DD/MM/YY)**	
Did the employee cease work?	☐ Yes ☐ No	**If yes, on what date (DD/MM/YY)**	
Is the employee still off work?			☐ Yes ☐ No
If no, what date did the employee return (DD/MM/YY)		**Is the employee on light of full duties**	☐ Light ☐ Full
Did the accident arise out of and in the course of the employment of the employee by the employer?			☐ Yes ☐ No

6. Earnings

Note if claiming for wages, include a statement indicating the employee's wages and the value of their benefits pair or allowed each week during the last 13 weeks. A medical certificate signed by the attending physician is necessary for all claims which involve loss of wages.

Weekly wage at the time of accident BD$ ____________________

7. Declaration

I/we the above named, do hereby, to the best of my/our knowledge and belief, warrant the truth of the foregoing statements in every respect and agree that if I have made any false or fraudulent statement or there be any suppression or concealment, the Policy shall be cancelled and the claim shall be forfeited.

I/we agree to provide additional information to the Company, if required.

Name	Signature of insured (employer)	Date (DD/MM/YY)

In your own interest, we advise you not to make any statement concerning your liability to any employee until the benefits have been properly authorized by a representative from the BF&M Claims Department.