The Argus Group

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Workers' Compensation/Short-Term Disability Claim Form

This form must be completed by the Employer together with the Employee and forwarded to the Argus Customer Service Centre without delay. Missing information will delay claim settlement.

A DOCTOR'S CERTIFICATE MUST ACCOMPANY THIS FORM WHERE WAGE REPLACEMENT PAYMENT IS EXPECTED.

Sections 1 through 3 to be completed for Workers' Compensation claims
Sections 1 through 4 to be completed for Short Term Disability claims

SECTION 1 – Details of Employer (to be completed by Employer)

1. **Employer:** _____ **Group Number:** _____

   Address: _____

   Telephone No.: _____

   Contact Person: _____

   E-mail Address: _____

Details of Employee (to be completed by Employee)

2. **Employee:** _____

   Home Address: _____

   Home Telephone No: _____

   E-mail Address: _____

   Date of Birth: _____

   Occupation at
   Date of Incapacity: _____

   Description of Job Duties: _____

   _____

   _____

   _____

   _____

SECTION 2 – Details of Accident & Incapacity

3. Date of accident/illness: _____

   Time: _____ Place: _____

4. Is employee in your direct employ? (Please tick one) Yes ☐ No ☐

   If "Yes":

Date employment commenced:	No. of regular days off work per week:	No. of hours worked per day:

5. Date the employee last worked: _____

6. At the time of the accident/illness was the employee actually doing work for you? (Please tick one) Yes ☐ No ☐

7. On what basis was the employee working for you? (Please circle one) Full Time | Part Time | Casual

8. State fully the type of work in which the employee was engaged at the time of the accident/illness:

   _____

   _____

   _____

9. Describe in detail how the accident/illness occurred:
   (If additional space is required, please complete description on another piece of paper and attach)

   _____

   _____

   _____

   _____

   _____

10. State nature and extent of injuries/illness:

    _____

    _____

11. When and to whom was the accident/illness first reported?

    _____

12. Name of physician in attendance for this injury: _____

    Date seen: _____

13. Has the employee been treated at the hospital? (Please tick one) Yes ☐ No ☐

    If "Yes", please provide dates of admission or treatment: _____

14. Was the accident due to anyone's negligence? (Please tick one) Yes ☐ No ☐

If "Yes", please give details and location including the owner of the property: _____

_____

_____

15. State names of any witnesses to the accident: _____

_____

_____

16. Has the employee returned to work since the date of incapacity? (Please tick one) Yes ☐ No ☐

If "Yes", please provide dates employee worked and a wage declaration: _____

_____

17. Is the employee able to perform any part of his / her duties? (Please tick one) Yes ☐ No ☐

18. Has the employee previously been absent from work with the same or similar condition? (Please tick one) Yes ☐ No ☐

If "Yes", please provide dates: _____

_____

19. State period of time lost due to injury/illness: _____

20. If claim is ongoing, please state estimated period of incapacity: _____

21. Name of employee's general practitioner: _____

SECTION 3 – Wages Statement (To be completed by Employer)

22. Wages at the time of the accident / sickness? Weekly _____ Monthly _____

23. Total value of Allowances (food, housing, etc.) Weekly _____ Monthly _____

Please Note: In the event of death or permanent disability, our case manager will contact you if additional information on the employee's wages is required.

SECTION 4 – To be completed by the Employer for Short-Term Disability Claims

Please Note: Complete this section for disability claims not related to employment

24. Nature of Incapacity: _____

Accident:	Yes:	No:			
Job Related:	Yes:	No:	Road Traffic Accident:	Yes:	No:
If Road Traffic Accident, was a third party involved?			Yes:	No:	
Illness:	Yes:	No:	Pregnancy:	Yes:	No:

25. Is the employee:

Still on payroll:	**Yes:**	**No:**	**Absent due to incapacity:**	**Yes:**	**No:**
Terminated:	**Yes:**	**No:**	**If "Yes", please provide date:**		
Back to Work:	**Yes:**	**No:**	**If "Yes"**	**Full Time:**	**Part Time:**
If "Back to work", please provide date:					

26. Does the employee plan to travel or reside outside of Bermuda during the period of incapacity? **Yes** ☐ **No** ☐

27. Was the employee under a contract of employment with any other employer at the time of incapacity? **Yes** ☐ **No** ☐

If "Yes", please provide name of other employer and details of employment: _____

_____

Important – Please read the following notes:

A claim for Workers' Compensation / Short Term Disability benefits should be submitted within 7 days following the date the disability commenced.

If the employee is absent from work due to incapacity for longer than 7 days, we may require the employee's physician to complete an Attending Physician's Statement form which should be returned to us as quickly as possible in order for your employee to be considered eligible to receive further benefits. Please contact our claims department and we will forward the appropriate form to the employee's physician.

The employee must notify Argus before leaving Bermuda in order to be eligible to receive benefit payments.

Medical Authorization

I authorize the disclosure and exchange of any relevant personal information about me that may be required for underwriting, administration and claims payment between any individual, public or private organization, including healthcare professional or practitioners, public or private health or social services institutions, insurance companies or financial institutions, investigation and credit reporting agencies, my current or former employers and Argus Management Services Limited, its reinsurer, agents or representatives. A photocopy of this confirmation authorization shall be as valid as the original. This authorization will be valid until revoked in writing.

Signature of Employee: _____ **Date:** _____

Please Print Your Name: _____

Declaration

I certify that the statements on this form, and on any attached sheets, are true and complete to the best of my knowledge and belief, and that no material information has been withheld or suppressed. I understand that a doctor's certificate must accompany this form where compensatory payment is expected.

Employer's Signature: _____ **Date:** _____

Please Print Your Name: _____

Employee's Signature: _____ **Date:** _____

Please Print Your Name: _____