ARGUS
Our Interest is You.

Worker's Compensation/ Short Term Disability Claim Form

Bermuda Life Insurance Company

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)

Employer	Group Number

Address

Contact Person

Telephone Number	Email Address

Details of Employee (to be completed by Employee)

Last Name	First Name	Middle Initial

Mailing Address

Telephone Number (Day-time)	Mobile Phone	Email Address

Date of Birth (MM/DD/YY)	Occupation at Date of Incapacity

Description of Job Duties

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SECTION 2 - Details of Accident & Incapacity		
Date of accident/illness	Time	Place
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
Date the employee last worked	At the time of the accident/illness was the employee actually doing work for you? (Please tick one}	
	☐ Yes ☐ No	
On what basis was the employee working for you?		
☐ Full-time ☐ Part-time ☐ Casual		
State fully the type of work in which the employee was engaged at the time of the accident/illness		
Describe in detail how the accident/illness occurred (If additional space is required, please complete description on another piece of paper and attach)		
State nature and extent of injuries/illness		
When and to whom was the accident/illness first reported?		
Name of physician in attendance for this injury		Date seen

Has the employee been treated at the hospital? (Please tick one)	If "Yes", please provide dates of admission or treatment
☐ Yes ☐ No	
Was the accident due to anyone's negligence? (Please tick one)	If "Yes", please give details and location including the owner of the property
☐ Yes ☐ No	

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State names of any witnesses to the accident	
Has the employee returned to work since the date of incapacity? (Please tick one)	**If "Yes", please provide dates employee worked and a wage declaration**
☐ Yes ☐ No	
Is the employee able to perform any part of his/ her duties? (Please tick one)	
☐ Yes ☐ No	
Has the employee previously been absent from work with the same or similar condition? (Please tick one)	**If "Yes", please provide dates**
☐ Yes ☐ No	
State period of time lost due to injury/illness	**If claim is ongoing, please state estimated period of incapacity**
Name of employee's general practitioner	

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

Wages at the time of the accident / sickness?
_____ 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		
Nature of Incapacity		
Accident	**Job Related**	**Road Traffic Accident**
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
If Road Traffic Accident, was a third party involved?	**Illness**	**Pregnancy**
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

Is the employee		
Still on payroll	**Absent due to incapacity**	
☐ Yes ☐ No	☐ Yes ☐ No	
Terminated	**If "Yes", please provide the date**	
☐ Yes ☐ No		
Back to Work	**If "Yes"**	**If "Back to work", please provide the date**
☐ Yes ☐ No	☐ Full-time ☐ Part-time	

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Does the employee plan to travel or reside outside of Bermuda during the period of incapacity?	
☐ Yes ☐ No	
Was the employee under a contract of employment with any other employer at the time of incapacity?	**If "Yes", please provide name of other employer and details of employment**
☐ Yes ☐ No	

Authorisation and Declaration

Important - Please read the following notes:

A claim for Workers' Compensation I 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 peligible to receive further benefits. Please contact our claims department and we will forward the appropriate form to the employee's hysician.

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

*Medical Authorisation

I authorise 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.

Name *(please print)* | Signature of Employee | Date (MM/DD/YY)

*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 beliet 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.

Employee's Name *(please print)* | Employee's Signature | Date (MM/DD/YY)

Employer's Name *(please print)* | Employer's Signature | Date (MM/DD/YY)