

# Employer's Indemnity Witness Statement

Claim no.

Policy no.

**This form should be completed and returned to CGU within 7 days of receipt by the insured.**

Please print in block letters and answer all questions. Tick  where applicable (provide full and complete answers). If a particular question does not apply, please write "Nil" in the space provided. If the space provided below is insufficient to advise all the details, please attach a separate sheet.

**Statement**

In support of claim by

I, Mr, Mrs, Miss, Ms (Name)

Address

Postcode

Employed by

Occupation

Are you an actual eye witness?

No  Yes

Are you a work colleague having knowledge of the occurrence?

No  Yes  Being a work colleague having knowledge of the occurrence giving rise to the disability

of  hereby certify that the particulars hereunder are an accurate description of the occurrence.

**Details of occurrence**

Date of occurrence

Time



If you were an **eye witness**, describe fully the occurrence giving rise to the disability.

If you were a **work colleague having knowledge of the occurrence giving rise to the disability**, state fully the source and circumstances from which knowledge of the occurrence was obtained.

## Details of disability

Describe the resulting disability. (State fully the type and position of the disability, for example 'cut on upper/lower arm, grazed right ankle, burnt back of left hand').


## Declaration

I acknowledge that Section 188 of the Workers Compensation and Injury Management Act 1981 provides that any person who by a false statement or other means, aids or abets a person in a fraudulent attempt to obtain any benefit under the Act commits an offence. I certify that this is a true statement.

I consent to CGU disclosing my personal information contained in this form to other insurers, insurance reference bureaux, investigators, or other parties providing services to CGU in relation to this claim.

Name of witness

Signature

Date

In the presence of

Signature

Date