

Registered Office

13 Stanmore Avenue, PO Box 837 Port of Spain, Trinidad & Tobago (t) +1 868 623 2266 (f) +1 868 623 9900 info@beacon.co.tt beacon.co.tt

PUBLIC LIABILITY

	PLEASE ANSWER EACH OF THESE QUESTIONS COMPLETELY ection B: details of accident				
iec					
	Date and time of accident: (mm/dd/yy) at (a.m./p.m.)				
	Location of accident:				
	How did the accident occur? (continue overleaf if necessary):				
	Names and addresses of witnesses, stating in each case whether the witness is your own employee or independent (continue overleaf if necessary):				
	What type of work were you or your employees engaged to do?				
	Do you consider yourself negligent?				
	Name and address of the person who in your opinion was to blame:				
	Name and address of his/her employer if other than the insured:				
	If particulars were taken by the police, state police station and case number:				
D.	Details of any other policies covering you for this accident:				
1.	Names and addresses of possible claimants:				

12.	Nature of injury or damage:	
13.	(a) Have you received any claim?	Yes No
	(b) If so, from whom and in what form?	
	If the claim is in writing, please attach to this form.	
Dec	laration	
l/we	hereby declare that the foregoing particulars are true and correct in every respect.	

Signature of employer:	Date:	(mm/dd/yy)
------------------------	-------	------------

Company stamp:

Please use this space to record additional details, quoting the question number referred to.

No.	Additonal details