TIP Friendly Society
80 Half Way Tree Road, Kingston 10
Tel: (876) 920-8399, (876) 960-0729
Toll Free: 1-888-991-4189

EMPLOYER'S STATEMENT
SICKNESS/ACCIDENT BENEFIT CLAIM

This statement must be completed by hand, by the employer, or his duly authorised agent, such as a Superintendent Paymaster, etc. It must not be completed by a clerk, Bookkeeper or Foreman, unless specially authorised; nor by ANY Representative of TIP Friendly Society.

1. Full Name of Insured: _____
2. Business Name of Insured's Employer: _____
3. Business Address of Insured's Employer: _____
4. Business Telephone Number of Insured's Employer: _____
5. State Insured's Occupation and Describe Duties _____

_____

6. Insured is employed on a ☐ Full-time Basis ☐ Part-time Basis
7. Insured's Salary is ☐ Weekly $ _____ ☐ Monthly $ _____
8. Insured has been incapacitated since _____ / ____ / ____ and gave up duties on _____ / _____ / _____
9. Insured is expected to/did resume duties on _____ / _____ / _____
10. Was injury or illness caused by reason of Insured's job? ☐ Yes ☐ No
11. If yes, please provide details _____

_____

12. Describe injury or illness which resulted in Insured's absence from work: _____

_____

13. Was the injury or illness the sole cause of Insured's absence during the stated period? ☐ Yes ☐ No
14. If no, please provide details _____

_____

15. Was there a period during which Insured performed only SOME of his duties? ☐ Yes ☐ No
16. If yes, please provide details _____

_____

I hereby certify that my answers to the foregoing questions are correct and true to the best of my knowledge and belief.

Employer's Signature _____ Date _____ / _____ / _____

Employer's Name (Please Print) _____

Title _____

_____
Employer's Stamp