IronRock INSURANCE

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By completing this form, you consent to the use of your data as outlined below:

Data Retention: We will keep the data you provide for 7 years as required by law. After that, it will be kept indefinitely for statistical and research purposes. Your privacy will be protected through anonymization or pseudonymization of the data.

Data Usage: During the retention period, your data may be used to fulfil legal obligations, respond to authorized inquiries, conduct internal analysis, direct marketing, and generate anonymized statistics.

Data Security: We implement measures to ensure the security and confidentiality of your data, including secure storage, restricted access, encryption, and monitoring.

Data Sharing: We may share your data with authorized third parties for legal compliance or research purposes, ensuring they comply with Jamaica's data protection requirements.

Your Rights: You have rights to access, rectify, erase, restrict processing, and data portability. For concerns or inquiries, please contact us.
For our full privacy statement please visit our website at https://www.ironrockjamaica.com/customer-care/privacy-and-security/

I consent to the data privacy terms above: _____

PUBLIC LIABILITY CLAIM FORM

Answering these questions does not imply that the injured person is making, or will make a claim

Preliminary particulars of the accident are to be furnished by the Employer

Policy Number _____

Name _____

Address _____

_____

Business _____

Telephone Nos Work _____ Mobile _____

Contact Person _____

Mobile Number _____

PARTICULARS OF POSSIBLE CLAIMANT

Name _____ Age _____

Home Address _____

_____

Department _____

Was He/She In Your Direct Employment? ☐ Yes ☐ No If So, From What Date _____

Name of Hospital Taken to _____

Where Is He/She Now? _____

ACCIDENT

Date Of Accident _____ Time _____ ☐ am ☐ pm

Location Of Incident: _____ Address: _____

Was The Injured Person In Your Direct Employ? _____

If Not, Give Name and Address of Contractor _____

How Long Had The Injured Person Been Employed By You? _____

Did He/She Work After The Accident? ☐ Yes ☐ No If So, From What Date _____

Was The Incident Reported? ☐ Yes ☐ No If So, To Whom? _____

On What Date? _____

Description of the Accident

What Was The General Nature of The Work Going On? _____

_____

_____

_____

Was Machinery Being Used? ☐ Yes ☐ No

If So, What Machinery Was Involved In The Incident? _____

_____

_____

Give Full Details of How the Incident Occurred _____

_____

_____

_____

_____

_____

_____

Was It Caused By: (a) Plant Not Owned By You? ☐ Yes ☐ No

(b) Anyone Not Employed By You? ☐ Yes ☐ No

Was He/She Doing His/Her Ordinary Work? ☐ Yes ☐ No

If No, What Was He/She Doing? _____

_____

_____

Nature Of Injury _____

_____

_____

_____

Name(s) & No(s) of Witness(es) Who Atually Saw the Accident

_____

_____

_____

I/We the undersigned Insured hereby declare that the above statements and facts are true and that I/We have not withheld from the Company any information within my/our knowledge connected with the claim.

Date _____ **Signature of Insured** _____