[reg.4]

FORM 2A

EMPLOYEES' COMPENSATION ORDINANCE (CAP. 282)

SECTION 15

NOTICE BY EMPLOYER OF THE DEATH OR INCAPACITY OF AN EMPLOYEE DUE TO OCCUPATIONAL DISEASE

Important Notes

(1) To be completed and returned in DUPLICATE to the Commissioner for Labour -

(a) WITHIN 7 DAYS of the death of the employee; or

(b) WITHIN 14 DAYS of the employee's incapacity; or

(c) WITHIN such period of time as required by the Commissioner for Labour.

(2) An employer who fails to give notice as required or who gives any false or misleading information to the Commissioner for Labour may be prosecuted.

(3) Please '✓' in the appropriate box.

(4) Please read the instructions carefully before completing this Form.

FORM 2A

EMPLOYEES' COMPENSATION ORDINANCE
(CAP. 282)

SECTION 15

NOTICE BY EMPLOYER OF THE DEATH OR INCAPACITY OF AN EMPLOYEE DUE TO OCCUPATIONAL DISEASE

To the Commissioner for Labour

I declare that the information given in this form is, to the best of my knowledge, true and accurate.

Signature : _____ (for and on behalf of the employer)

Name (in block letters) : _____

Position : ☐ Sole proprietor ☐ Partner ☐ Manager ☐ Officer

Date : _____ _____ Chop of Company ***(Note 1)***

A. Particulars of the employee

Name of employee (Surname first)			Identity Card/Passport No.
Telephone No.	Fax No.	Address	
Date of Birth _____ /_____ /_____ Day/Month/Year	Sex ☐ Male ☐ Female	Occupation	
An apprentice ☐ Yes ☐ No	Duration of employment From _____ to _____		

B. Particulars of employer

Name of employing company/person		Business Registration Certificate No. ***(Note 2)***
Telephone No.	Address	Trade
Fax No.		

C. Particulars of principal contractor/holding company ***(Note 3)***

Name of principal contractor/holding company		Business Registration Certificate No.
Telephone No.	Address	Trade
Fax No.		

D. Particulars of the occupational disease

Name of hospital or clinic where the employee received treatment	
Date of commencement of the occupational disease _____ /_____ /_____ Day/Month/Year	Disease suffering from
Type of work attributed to the occupational disease	The disease resulted in ☐ temporary incapacity ☐ permanent incapacity ☐ death on _____ /_____ /_____ Day/Month/Year

E. Details of insurance ***(Note 4)***

Name and address of insurance company at the time of the employee's incapacity or death (Please refer to the insurance policy)	Policy No.

F. Details of earnings of the employee

Average number of working days per month	Rest day is
☐ 22 ☐ 24 ☐ 26 ☐ 30 ☐ Others _____ (please specify)	(a) ☐ not paid ☐ paid (b) ☐ not fixed ☐ fixed on _____ (Day of week)

Details of earnings per month for the month immediately preceding the date of the employee's incapacity or death: ***(Note 5)***

(a)	Basic salary/wages	$ _____ / month
(b)	Food allowances/value of free food provided by employer	$ _____ / month
(c)	Other items : _____ (please specify)	$ _____ / month
	Total (a) + (b) + (c)	$ 0.00 / month

Average monthly earnings of the employee for the past 12 months (or total period of employment, if less than 12 months) preceding the employee's incapacity or death were

$ _____ / month

G. Fatal case (to be completed where the occupational disease results in death)

Whether police was notified	Name and address of next-of-kin of the deceased employee	Relationship with the deceased employee
☐ Yes _____ (name of police station) ☐ No		Telephone No.

H. Direct settlement (to be completed only where the occupational disease results in temporary incapacity for not more than 7 days and no permanent incapacity, and the employer and employee have chosen to directly settle the employees' compensation claim)

Period of sick leave	Amount of compensation:
from ____ / ____ / ____ to ____ / ____ / ____ Day / Month / Year Day / Month / Year ____ / ____ / ____ to ____ / ____ / ____ Day / Month / Year Day / Month / Year Total number of sick leave days : _____ days	$ _____ ☐ paid ☐ to be paid on ____ / ____ / ____ Day / Month / Year

Explanatory Notes

Note 1: The signature and company chop which appear in both copies of Form 2A submitted to the Commissioner for Labour should be in the original.

Note 2: If the Business Registration Certificate No. is not available, the Identity Card No. of the employing person should be entered.

Note 3: Section C on particulars of principal contractor/holding company should be completed only when the employer is either :

(a) a subcontractor; or

(b) a subsidiary of a holding company within the meaning of the Companies Ordinance (Cap. 32) and which is covered by and specified in the insurance policy taken out by the group of companies to which it belongs.

Note 4: The name and address of the insurer as appeared on the insurance policy, instead of those of the broker or agent, should be entered here.

Note 5: Earnings include :

(a) cash wages;

(b) the value of any privilege or benefit which can be estimated in cash, e.g. food, fuel or quarters supplied to the employee if, as a result of the accident, he is deprived of any of them;

(c) overtime or other special remuneration for work done, whether in the form of bonus, allowance or otherwise, if it is of a constant nature; and

(d) customary tips.

But remuneration for intermittent overtime, casual payments of a non-recurrent nature, the value of travelling allowances or concession and the employer's contributions to provident funds are not included.