

## Liability Claim Report

Please return to:

Claim No: (Office Use Only)

Please answer all relevant questions fully and return this form within seven days.

INSURED	
Policy No:	<input style="width: 95%;" type="text"/>
Full Name:	<input style="width: 95%;" type="text"/>
Address:	<input style="width: 95%;" type="text"/>
	<input style="width: 95%;" type="text"/>
	<input style="width: 65%;" type="text"/> Postcode <input style="width: 10%;" type="text"/> - <input style="width: 10%;" type="text"/>
Business or Occupation	<input style="width: 95%;" type="text"/>
Business Telephone No.	<input style="width: 15%;" type="text"/> - <input style="width: 30%;" type="text"/> Residence Telephone No. <input style="width: 15%;" type="text"/> - <input style="width: 30%;" type="text"/>

THE EVENT	
Date of Incident: <input style="width: 15%;" type="text"/> / <input style="width: 15%;" type="text"/> / <input style="width: 15%;" type="text"/>	Time of Loss: <input style="width: 40%;" type="text"/> AM/PM
Exact place of accident giving rise to claim <input style="width: 95%;" type="text"/>	
When was the accident report to you <input style="width: 60%;" type="text"/>	
Have you any other insurance in force which may cover this loss Yes <input type="checkbox"/> No <input type="checkbox"/>	
<i>If 'Yes' please give details below</i> <input style="width: 95%;" type="text"/>	
Policy No:	<input style="width: 45%;" type="text"/> Insurer: <input style="width: 45%;" type="text"/>
Address:	<input style="width: 95%;" type="text"/>
	<input style="width: 95%;" type="text"/>

DETAILS OF CLAIM
Give details of any claim made upon you (enclose any correspondence that you may have received relating to the claim with this form)
<input style="width: 95%; height: 20px;" type="text"/>
<input style="width: 95%; height: 20px;" type="text"/>
<input style="width: 95%; height: 20px;" type="text"/>
<input style="width: 95%; height: 20px;" type="text"/>

DETAILS OF THE INCIDENT
Please describe the accident in details
<input style="width: 95%; height: 20px;" type="text"/>
<input style="width: 95%; height: 20px;" type="text"/>
<input style="width: 95%; height: 20px;" type="text"/>
Please give name and address of all witness to the accident
<input style="width: 95%; height: 20px;" type="text"/>
<input style="width: 95%; height: 20px;" type="text"/>
<input style="width: 95%; height: 20px;" type="text"/>

## DAMAGE TO PROPERTY

Please state name and address of each owner of damaged property and give full details of such damage


Was any of the above known to the insured before the accident? Yes  No

If 'Yes', please state relationship

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## PERSONAL INJURY

Please give name, occupation and employer's name in respect of each injured person and details of the injuries sustained in the incident

Name	Occupation	Employer	Injuries

If the injured person is one of your employees, please also answer the following questions

How long has he/she been employed by you (a) altogether  (b) in his/her present capacity

Approximately weekly wage inclusive of overtime and any bonus, excluding income tax £

Age  Married or Single  Dependant children of school age

If the injured person has been absent from work as a result of the accident

a) When did the absence begin  /  /  (b) Date of return to work, or expected date if still absent  /  /

If the injured person has returned to work is he/she now performing full pre-accident work? Yes  No

If 'No', please give details

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What was the injured person doing at the time of the accident

Who was in charge of their work

Was any machinery involved? Yes  No

If 'Yes', please give details

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Was the accident due to the lack of or non use of guarding

Was the accident due to any defect in the premises or plant

Use this space for any additional information that you may wish to give


## DECLARATION

I/We hereby declare that to the best of my knowledge and belief these particulars are true and complete.

Date  /  /

Signature:

Position:

(If signed on behalf of a company)

Note: The Company does not admit any liability by the issue of this form