

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:

Full Name:

Address:

Postcode

Business or Occupation

Business Telephone No.

Residence Telephone No.

THE EVENT

Date of Incident:

Time of Loss:

AM/PM

Exact place of accident giving rise to claim

When was the accident report to you

Have you any other insurance in force which may cover this loss

If 'Yes' please give details below

Policy No:

Insurer:

Address:

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)

DETAILS OF THE INCIDENT

Please describe the accident in details

Please give name and address of all witness to the accident

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

Members of the Association of British Insurers
Authorised by the Prudential Regulation Authority and Regulated by the Financial Conduct Authority & the Prudential Regulation Authority

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