

EMPLOYERS' LIABILITY CLAIM FORM

CERTIFICATE NO:

ASSURED

Address

Nature Of Business

Telephone No Contact Name

EMPLOYEE (Name In Full)

Address

Usual Occupation Date Of Birth

Single Or Married

Date Entered Your Employ National Insurance No

If Employer Not As Above Give Subcontractors Name And Address

ACCIDENT Date Time Location

To Whom Reported? When Reported (Date And Time)

On What Work Was Employee Engaged At Time Of Accident?

Was the injured person performing a duty for which he/she was employed?

Was the accident due to any breakdown or defect in ways, works, machinery or plant?

Who was in charge at time of accident and in what capacity?

Describe fully how the accident occurred

If accident was caused by machinery, describe type and make

If thought necessary, a rough sketch or diagram would be helpful

INJURIES

Nature and Extent

Date Employee ceased work

Has employee returned to work ? If yes, state date

If taken to hospital, state name and address thereof and whether detained

WITNESSES (Give names and addresses)

EARNINGS

Give a list of the injured person's earnings for the 3 months prior to the date of accident (NB. This information is only required when injured person is likely to be totally incapacitated for a period in excess of 14 days).

Week Ending	Gross Wages	Nett Wage
1		
2		
3		
4		
5		
6		
7		
8		
9		
10		

NB. Wages given should not include allowances.

I/We certify the particulars supplied herein to be true to the best of my/our knowledge and belief.

Date _____ Assured's Signature _____

NB. You are reminded that in no circumstances should you admit any liability or make any offer or enter into any correspondence in connection with any incident which may result in a claim under your policy.