Claims Reference No. (if known)

EMPLOYERS' LIABILITY CLAIM FORM

1. You the Policyholder

Name of Insured

Address

Postcode

Contact Number

Policy Number

Business Name

Date Premium Paid

Are you a Registered Trade for VAT purposes? Yes No

If Yes - VAT Reg Number

If Yes, state whether you can recover the VAT relating to the property for which you are claiming.

Name of Employee

Address

Postcode

National Insurance No.

Occupation

Date of Birth

Marital Status

2. General Information

a. Was he/she in your employ and pay? Yes No

b. If he/she is in your direct employ were instructions/ supervision given by your employees? Yes No

c. If he/she is employed by or receives instruction/supervision from a contractor to you or persons to whom you are contracted, state their name/address.

d. The following documents are requested

Pre-action protocol and fast track discovery

	Enc	Available	Not Held
1. Accident Book entry			
2. First Aider's report			
3. Forman/Superviser's accident report			
4. Safety representatives accident report			
5. RIDDOR report to HSE			
6. Other communications between defendants/HSE			
7. Minutes of Health & Safety committee/ meetings where accident/matter considered			
8. Report to DSS			
9. Documents relative to any previous/ accident/ matter identified by the Claimant and relied upon as proof of negligence.			

You should not delay the submission of this form if any of the above are not readily available

e. Date of commencement of employment

f. For the 13 weeks prior to the accident, please state

i) Gross earnings

ii) Income Tax deducted

iii) NI benefits deducted

iv) Net Earnings

Please indicate total number if weeks (if not 13 weeks)

g. State total periods of absence in 52 weeks prior to accident divided into causes:

Cause | Period | Paid/Unpaid

Cause | Period | Paid/Unpaid

h. If employment was of casual nature, state

i) How was he/she being paid

ii) What was the weekly wage

iii) Details of any deductions

iv) Payments from any other employers

3. Circumstances of the Claim

a. Date of Accident Time am/pm

b. Place

c. When was the accident first reported to you or your representative?

d. Describe nature of work being performed at time of the accident?

e. By whom?

f. Description of the accident

g. If the accident involves machinery:

i) Was it properly guarded? Yes No

ii) Was the guard in use Yes No

h. Has H.M. Factory Inspector examined the machinery/premises since the accident?

Yes No Date of examination / / 20

j. Name and address of negligent person

k. Name and address of negligent employers

l. Details of the negligence

m. Name and position of person in authority over injured employee

Name

Position

n. Was the injured employee doing the work he/she should have been doing and in the correct way?

Yes ☐ No ☐

If 'No', please give details

o. Names and addresses of witnesses. If employees of yours state their position(s)

Witness One

Name

Position

Address

Witness Two

Name

Position

Address

p. Nature of the injuries (please give as much detail as possible)

q. If removed to hospital or otherwise medically examined state name and address of hospital or doctor

r. If removed to hospital, was this by NHS ambulance? Yes ☐ No ☐

Was the injured person detained? Yes ☐ No ☐

If 'Yes', for how many nights?

s. State date on which injured employee:

i) Was first unable to work due to this incident? / / 20

ii) Returned to any part of former work / / 20

iii) Returned to any form of work / / 20

iv) If not yet returned, date expected to be able to resume work / / 20

t. Have you received notice of claim? Yes No

If 'YES' from whom, when and in what form (if claim in writing please forward original with this form)

PLEASE DO NOT ENTER INTO ANY CORRESPONDENCE WITH THE INJURED EMPLOYEE OR HIS REPRESENTATIVES. SIMILARLY NO PAYMENTS, OFFERS OR ADMISSIONS OF LIABILITY ARE PERMITTED BY YOUR POLICY. ANY SUCH ACTION COULD PREJUDICE THE POSITION ADVERSELY.

IN RESPECT OF FATAL ACCIDENTS OR SERIOUS INJURIES WHICH MAY OR MAY NOT PROVE FATAL IMMEDIATE TELEPHONE NOTIFICATION IS REQUIRED.

I/WE DECLARE THESE PARTICULARS ARE TRUE AND COMPLETE IN EVERY RESPECT.

INSURERS AND THEIR AGENTS SHARE INFORMATION WITH EACH OTHER TO PREVENT FRAUDULENT CLAIMS AND FOR UNDERWRITING PURPOSES VIA THE CLAIMS AND UNDERWRITING EXCHANGE REGISTER, OPERATED BY INSURANCE DATABASE SERVICES LTD. A LISTOF PARTICIPANTS IS AVAILABLE ON REQUEST. THE INFORMATION YOU SUPPLY ON THIS FORM, TOGETHER WITH THE INFORMATION YOU HAVE SUPPLIED ON YOUR APPLICATION FORM AND OTHER INFORMATION RELATING TO THE CLAIM, WILL BE PROVIDED TO PARTICIPANTS.

Signature of Insured

Name

Designation of Signatory

Date