Employers Liability Claim Form

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IMPORTANT NOTE

We aim to provide you with prompt and careful handling of your claim. To help us to help you please ensure that all relevant questions are answered as fully as possible (continue your answers on a separate page if necessary).

In addition you should:

- Contact your insurance broker if you need assistance
- Provide all documentation in support of your claim, such as medical certificates, but do not delay submitting this form if such documents are not immediately available
- Complete the form clearly and in BLOCK CAPITALS

Applicant Details

Policy number

Name of policy holder

Insuring broker

Name of official to be contacted in connection with this accident

Are you registered for VAT ◯ Yes ◯ No

Postal address

Postcode Telephone

Email

Accident Details

Name of injured person

National Insurance Number

Actual occupation: Length of service

Address

Postcode Date of birth

How long had the employee worked in the department where the accident occurred:

Supervisor's name

Grade Contact no:

Approximately how many times had the employee carried out the task before:

Accident Details Continued

Was the employee responsible for the same task at a previous employer: ◯ Yes ◯ No

Name of previous employer

Address

Address where accident occurred

Date of accident Time of accident

When did you receive notice of the accident

From whom

Give full description of the accident, how it occurred, and what work the employee was doing at the time

Other relevant factors (e.g. weather conditions; wet floors; obstacles; poor lighting etc)

Vehicle registration or serial number (Where applicable)

Where is the equipment involved currently kept? *NB: Ensure that the machinery, plant, tool(s), etc involved in the accident are retained by you until notified in writing by the Insurer that it may be disposed of.*

Was the person authorised to do the job? ◯ Yes ◯ No

Is there a written risk assessment? ◯ Yes ◯ No

Was the risk assessment being followed? ◯ Yes ◯ No

Was the person trained to do the job? ◯ Yes ◯ No

Was the person carrying out his normal job? ◯ Yes ◯ No

Name of trainer:

Date of training:

Personal protective equipment worn:

☐ Safety footwear ☐ High visibility clothing ☐ Gloves

Other *(e.g. hard hat, harness, safety glasses, ear defenders, etc)*

What type of injury was it

What body part was injured

Did it involve an industrial disease *(e.g. dermatitis, stress, work related upper limb disorder/Repetitive strain injury, etc)*

Was First Aid treatment provided ◯ Yes ◯ No

Name of First Aider

Contact number

What lost time was incurred by the accident

☐ No injury (near miss) ☐ Reported back to work ☐ Deployed on light duties

☐ Off work for 3 days or less ☐ Off work for more than 3 days ☐ Hospitalised

☐ Conveyed by ambulance

For how long was the employee in hospital

Witnesses

1st witness's name:

Address:

Postcode **Telephone**

Employer

2nd witness's name:

Address:

Postcode **Telephone**

Employer

3rd witness's name:

Address:

Postcode **Telephone**

Employer

4th witness's name:

Address:

Postcode **Telephone**

Employer

RIDDOR Reporting

For major injuries or over-three-day injuries, work related diseases, and dangerous occurrences (near miss accidents)

Is the accident/incident reportable ◯ Yes ◯ No

Has the accident/incident been reported ◯ Yes ◯ No

Date of report:

Report reference number:

Police Reporting

Has the accident been reported to the police ◯ Yes ◯ No

Name of Police Officer

Name of station

What work were your employees doing

Was the work being carried out under contract ◯ Yes ◯ No *A copy of the contract may be required.*

Do you accept responsibility for the accident ◯ Yes ◯ No

If not, who do you consider responsible and why

Documentation

Please attach as many of the following documents as possible: copy of accident book entry; statement from injured party; sketch / measurements; relevant training records; witness statement(s); photographs; service records; risk assessment(s); post-accident risk assessment(s); earnings information; RIDDOR report to HSE; other communications with HSE; minutes of health & safety committee meeting(s) where accident/matter was considered; report to DSS; reports of any previous similar accidents or any other that may apply

Has any claim been made upon you to date? ◯ Yes ◯ No

If so, please state when and whether verbally or in writing (if in writing attach a copy of the letter)

Investigating Manager

Name: Job Title

Signature Date * 06/07/11

Declaration

◯ I declare all the information given above to be true and complete to the best of my knowledge and belief and I have no other Insurance which will respond to this claim.

Name:

Signature Date * 06/07/11

Print Form Submit by Email