Product Liability Claim Form

Lloyd's Avenue House
6 Lloyd's Avenue
London
EC3N 3AX

Tel: 0870 142 0871 Fax: 0870 142 0872

Email: commercialclaims@lroinsurance.co.uk

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

Injured person

Postal address

Postcode Date of birth

Address where accident occurred

Date of accident

Time of accident

When did you receive notice of the accident

From whom

Accident Details Continued

Give full **description** of the accident and state exactly how it occurred

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

Vehicle registration or serial number (Where applicable)

What type of injury was it

What body part was injured

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 ◯ Off work for 3 days or less

◯ Off work for more than 3 days ◯ Deployed on light duties ◯ Hospitalised

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

5th witness's name:

Address:

Postcode **Telephone**

Employer

Product Details

Please identify product involved

Any explanation literature or brochures concerning the product would be helpful to Insurers.

Model

Serial no

NB. Please ensure that you retain the product in question

Do you manufacture the product? ◯ Yes ◯ No

If not, please advise manufacturer's name:

Manufacturer's address:

Postcode

Telephone

Did you supply the product directly to the Claimant(s) ◯ Yes ◯ No

If not, please advise intermediary supplier's name:

Intermediary supplier's address:

Postcode

Telephone

Was the product supplied with any special instructions for use? ◯ Yes ◯ No

If it is considered that a failure to comply with such instructions has contributed to or caused the accident please forward a copy of the relevant instructions.

Has the product been returned by the Claimant and/or supplier for testing? ◯ Yes ◯ No

If so, please provide a copy of any technical report prepared.

Do you accept an allegation of faulty manufacture of your product? ◯ Yes ◯ No

Do you accept an allegation of faulty design to your product? ◯ Yes ◯ No

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); 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