

Employers' Liability Claim Form



10 Sabre Close, Green Farm Business Park, Quedgeley, Gloucester GL2 4NZ
 Telephone: 01452 361602 or 361649 Facsimile: 01452 361604

- When completing this form, please tick the appropriate boxes and answer all questions using BLOCK CAPITALS.

1 You the Policyholder

Name of the Insured

Address

Town County

Postcode Date Premium Paid

Occupation Telephone Number

Policy Number Value Added Tax. Are you a registered person or company? Yes No

Name of Employee

Address

Town County

National Insurance No. Occupation

Date of Birth Age 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 instructions/supervision from a contractor to you or persons/company to whom you are contracted, state their name/address

- d The following documents are requested:

Pre-action Protocol and Fast Track Discovery	Tick (✓) appropriate box		
	Enclosed	Available	Not held
1 Accident book entry	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2 First Aider's report	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3 Foreman/Supervisor's accident report	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4 Safety representatives accident report	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5 Riddor report to HSE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6 Other communications between defendants/HSE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7 Minutes of Health & Safety committee/meetings where accident/matter considered	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8 Report to DSS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9 Documents relative to any previous accident/matter identified by the Claimant and relied upon as proof of negligence.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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

2 General Information *continued*

e Date of commencement of employment?
 (dd/mm/yyyy)

f For the 52 weeks prior to the accident, please state:

i Gross earnings £ <input type="text"/>	ii Income Tax deducted £ <input type="text"/>
iii N.H.I. benefits deducted £ <input type="text"/>	iv Net Earnings £ <input type="text"/>

Please indicate total number of weeks (if not 52 weeks)

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

Cause

Period <input type="text"/>	Paid/Unpaid? <input type="text"/>
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Cause

Period <input type="text"/>	Paid/Unpaid? <input type="text"/>
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h If employment was of casual nature, state:

i How was he/she being paid

ii What was the weekly average

iii Details of any deductions

iv Payments from any other employers

3 Circumstances of the Claim

a Date of Accident (dd/mm/yyyy) 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 the time of the accident

e Description of the accident

f If the accident involves machinery:

i was it properly guarded?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
ii was the guard in use	Yes <input type="checkbox"/>	No <input type="checkbox"/>

g Has H.M Factory Inspector examined the machinery/premises since the accident?
 Yes No

If **yes**, date of examination (dd/mm/yyyy)

h Was the accident caused by negligence? Yes No

i Name and address of negligent person

j Name and address of negligent employers

k Details of the negligence

l Name and position of person in authority over injured employee

Name

Position

3 Circumstances of the Claim *continued*

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

Yes No

If **no**, please give full details

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

i Name	<input type="text"/>
Position	<input type="text"/>
ii Name	<input type="text"/>
Position	<input type="text"/>
iii Name	<input type="text"/>
Position	<input type="text"/>
iv Name	<input type="text"/>
Position	<input type="text"/>

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

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

q State date (dd/mm/yyyy) on which employee:

i Left off work	<input type="text"/>
ii Returned to any part of former work	<input type="text"/>
iii If not yet returned, date expected to resume	<input type="text"/>

r Have you received notice of claim? Yes No

If **yes**, from whom, when and in what form (if claim in writing please forward 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 to decide whether to accept your proposal and, if so, on what terms via the Claims and Underwriting Exchange Register, operated by Insurance Database Services Ltd. A list of 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

Date (dd/mm/yyyy)

Designation of Signatory



NIG policies are underwritten by U K Insurance Limited, The Wharf, Neville Street, Leeds LS1 4AZ.
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