

# Public 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	<input type="text"/>		
Address	<input type="text"/>		
Town	<input type="text"/>	County	<input type="text"/>
Postcode	<input type="text"/>	Date Premium Paid	<input type="text"/>
Business/Occupation	<input type="text"/>	Telephone Number	<input type="text"/>
Policy Number	<input type="text"/>	Value Added Tax. Are you a registered person or company?	Yes <input type="checkbox"/> No <input type="checkbox"/>

## 2 Circumstances of the Claim

<p><b>a</b> Date (dd/mm/yyyy)      Time</p> <p><input type="text"/>      <input type="text"/> am/pm</p> <p><b>b</b> Exact place where Accident/Loss occurred</p> <p><input type="text"/></p> <p><input type="text"/></p> <p><b>c</b> Give full details of how the accident occurred</p> <p><input type="text"/></p> <p><input type="text"/></p> <p><input type="text"/></p> <p><input type="text"/></p> <p><input type="text"/></p> <p><input type="text"/></p> <p><b>d</b> Name and Address of the Person who caused the Accident</p> <p><input type="text"/></p> <p><input type="text"/></p> <p><input type="text"/></p> <p><input type="text"/></p> <p><b>e</b> Name and Address of his/her employers</p> <p><input type="text"/></p> <p><input type="text"/></p> <p><input type="text"/></p>	<p><b>f</b> Describe the work you or your employees were engaged to do</p> <p><input type="text"/></p> <p><input type="text"/></p> <p><input type="text"/></p> <p><b>g</b> Total number of your men employed on the contract</p> <p><b>i</b> direct employees      <input type="text"/></p> <p><b>ii</b> sub-contractors under your direction whether or not labour only</p> <p><input type="text"/></p> <p><b>h</b> Name and Address of the Company/Person for whom you were working and/or under contract</p> <p><input type="text"/></p> <p><input type="text"/></p> <p><input type="text"/></p> <p><input type="text"/></p> <p><b>i</b> Who were the Main Contractors?</p> <p><input type="text"/></p> <p><input type="text"/></p>
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## 2 Circumstances of the Claim *continued*

**j** Give the name of the person injured, or of the owner of the damaged property

  


**k** Address

  
  


**l** Occupation

**m** Is this person in your service? Yes  No

If **no**, state Name and Address of his/her Employers

  
  
  


## 3 General Information

### Damage

**a** Description of the property damaged

  
  
  


**b** Nature and extent of the damage

  
  
  


**c** Where can the damaged property be inspected?

  


### Injury

**d** Nature of the injury

  


**e** Date ceased work (dd/mm/yyyy)

**f** Date resumed (dd/mm/yyyy)

**g** Name of the hospital to which the injured person was taken

**h** Was the injured person detained?

**i** Give the name and address of all witnesses: (indicate if own employee or independent)

  
  


**j** Have the police taken particulars? Yes  No

If **yes**, state identity of Officer and Station to which he/she attached.

  


**k** Have you received notice of the claim? Yes  No

If **yes**, from whom, when and in what form?

  


If the claim is in writing please forward with this form

**l** Have any steps been taken to compromise or settle the matter in anyway?

Yes  No

If **yes**, what and by whom?

  


**m** Are there any other policies covering you for this accident?

Yes  No

If **yes**, give details

### 3 General Information *continued*

n The following documents are requested:

Insured	Claim Number	Broker Reference
<input type="text"/>	<input type="text"/>	<input type="text"/>

Standard Document Disclosure List	
Document	Available
Records of inspection for the relevant area	Yes / No
Maintenance records including reports of independant contractors working in relevant area	Yes / No
Records of the minutes of meetings where maintenance or repair policy has been discussed or decided	Yes / No
Records of complaints about the state of the area	Yes / No
Records of other accidents which have occured on the relevant area	Yes / No
Copies of any contracts or other documents relating to sale or agreement	Yes / No
Copies of leases if accident involves premises	Yes / No

I/We declare that no material information has been withheld and that all statements on this form are true to the best of my/our knowledge and belief. In addition the articles and property belong to the persons named and no other person has any interest whether as Owner, Mortgagee or Trustee. I/We understand that you may seek information from other insurers to check the answers I/we have provided, and I/we authorise the giving of such information for such purposes.

**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 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)
<input type="text"/>	<input type="text"/>

Please complete and return this form as soon as possible. Damaged property should be protected from further deterioration but not disposed of without prior reference to the Company. If the claim is for repairable damage i.e. buildings, a Trademan's estimate will be required.

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