

LIABILITY INCIDENT REPORT FORM

Please return completed Report Form to:

Policy Number

Claim Reference (if known)

NOTE: Please use separate sheet(s) of paper to respond to questions if there is insufficient space on the form.

A. POLICYHOLDER

Name

Address

Tel No. Postcode

Contact Name

Tel No.

Business

Are you registered for VAT? Yes No If 'Yes', state rating (full, partial, exempt) % if partial.

B. INCIDENT

Date and time

Place

Circumstances – What happened and what was the cause?

Please carefully preserve any broken parts of machinery, plant, equipment, tool, or other relevant item involved in the incident

WITNESSES

Name	Address	Where was witness at time of incident?	Relationship to Injured Party/Property owner

To whom was the incident first reported and when?

C. EMPLOYEE DETAILS

Complete this section only if an employee is injured

Name/Address	
Date of Birth	National Insurance Number
Full or Part Time	Nature of Employees job
How long has Employee been with company?	How long has the Employee held this position?
Has the Employee been absent from work as a result of the incident? Yes <input type="checkbox"/> No <input type="checkbox"/>	If 'Yes', give dates of absence From _____ To _____
Give details of employee's net weekly wage _____ pw	or net monthly salary _____ pm
Give details of company sick pay due weekly _____ pw	or monthly _____ pm
Have you completed H.S.E. Form 'Report of Injury or Dangerous Occurrence'? If 'Yes', please enclose a copy	Yes <input type="checkbox"/> No <input type="checkbox"/>
Have you completed H.S.E. Form 'Report of a Case of Disease'? If 'Yes', please enclose a copy	Yes <input type="checkbox"/> No <input type="checkbox"/>
Please enclose copy of relevant Accident Book entry	
Did employee receive any first aid or other treatment?	Yes <input type="checkbox"/> No <input type="checkbox"/>
If 'Yes', please give details of what treatment was administered, and by whom	

D. INJURIES/DAMAGE/DISEASE

Give whatever details you can about the extent and nature of the injury/damage/disease
Give name(s) and address(es) of person(s) injured or whose property was damaged

E. CLAIM

Has any claim been made by, or on behalf of, the Third Party/Employee? If so, give date of claim, by whom and whether written or verbal, together with details of the nature of the damage, loss or injury. (If not stated above).

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Any letter or document you receive should be passed to us immediately and unanswered.

F. DECLARATION

I/We hereby declare that the information given is true to the best of my/our knowledge and belief

Signature	_____	Date	_____
Print name	_____		
	Position/Job Title		