

# Employers Liability Claim Form



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NIG is the trading name of The National Insurance and Guarantee Corporation Ltd  
Registered office: As above Registered in England and Wales number 42133

## 1 YOU THE POLICY HOLDER

Name of Insured	<input type="text"/>			
Address	<input type="text"/>			
Town	<input type="text"/>		County	<input type="text"/>
Post code	<input type="text"/>	Date Premium Paid	<input type="text"/>	
Business	<input type="text"/>	Telephone No	<input type="text"/>	
Policy No	<input type="text"/>	Value Added Tax. Are you a registered person or company?	<input type="text"/>	
Name of Employee	<input type="text"/>			
Address	<input type="text"/>			
National Insurance No	<input type="text"/>	Age	<input type="text"/>	
Occupation	<input type="text"/>	Marital Status	<input type="text"/>	

## 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** Date of commencement of employment?

**e** For the 52 weeks prior to the accident (or any lesser period employed) please state:

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

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

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

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

**g** If employment was of casual nature, state:

<b>i</b> How was he/she being paid	<input type="text"/>
<b>ii</b> What was the weekly average	<input type="text"/>
<b>iii</b> Details of any deductions	<input type="text"/>
<b>iv</b> Payments from any other employers	<input type="text"/>

## 3 CIRCUMSTANCES OF CLAIM

**a** Date of Accident  Time  a.m/p.m.

**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?

**f** Description of the accident

**g** If the accident involves machinery:

**i** Was it properly guarded? YES/NO

**ii** Was the guard in use YES/NO

**h** Has H.M Factory Inspector examined the machinery/premises since the accident? YES/NO  Date of examination

**i** Was the accident caused by negligence? YES/NO

**j** Name and address of negligent person

**k** Name and address of negligent employers

**l** Details of the negligence

**m** Name and position of person in authority over injured employee

Name

Position

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

If 'NO' please give full details

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

Name

Position

Name

Position

Name

Position

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

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

**r** State date on which employee:

**i** Left off work

**ii** Returned to any part of former work

**iii** If not yet returned, date expected to resume

**s** Have you received notice of claim?

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 of Insured

Designation of Signatory

Date