EMPLOYERS LIABILITY CLAIM FORM

Insured

Insured | Policy Number

Address

Postcode

Type of Business | VAT registered? Yes No

Annual Turnover £ | Non-clerical wage roll

Contact

Please provide details of the person we should contact regarding this matter: -

Name and position

Telephone Daytime | Telephone Evening

Mobile Telephone No

Please note this person must be available to discuss the incident

Employee

Full Name

Date of Birth / / / National Insurance Number

Address

Post Code

Occupation

Is the employee in your direct employ? Yes No Full time? Yes No

Period of employment

If not employed by you give details of employer

Name and Address of Employer

Injury

What injuries did the employee sustain?

Where was the employee treated?

Was the employee detained in hospital Yes No

Date Ceased work | Date Returned to work

If still absent confirm date sick note expires and/or date due to return

Witness

Name | Address

Telephone | Employee | Yes | No

Name | Address

Telephone | Employee | Yes | No

Name | Address

Telephone | Employee | Yes | No

COMPLETE THIS SECTION OF THE FORM IF THE CLAIM RELATES TO AN ALLEGED INDUSTRIAL DISEASE

Nature of disease

To what is it attributed? (nature of substance, material or irritant)

Was employee asked if he/she suffered from this complaint before entering your employ?

Yes No

If 'Yes' please supply details

Date upon which you were notified of the disease

Date upon which employee ceased work

Describe the nature of the employees work

Has the employee received treatment for the disease on your premises? Yes No

Has any other employee suffered from the same disease? Yes No

If 'yes' please provide name and dates

Name		Date
Name		Date
Name		Date

Are any precautions taken to prevent the disease? Yes No

If 'yes' please provide details

Accident Details

Date and time of accident | | Place | |

To whom was the accident reported? | |

Date and time reported | am/pm |

Was entry made in an accident book? Yes No (if yes attach a copy)

Was the accident reported to the HSE? Yes No

Please describe in full how the accident occurred (attach plans/sketches/photos)

Who was responsible for the accident and why?

What precautions were taken to prevent such an accident?

Machinery

If machinery is involved please give details:

Make | | Model | |

Year of manufacture | | Date of Purchase | |

Who owns the machinery

EARNINGS DETAILS - PLEASE COMPLETE IN ALL CASES

Please supply details of earnings for 13 weeks leading up to the incident

Week Ending	Gross Pay	Income Tax	Employees National	Net Pay
Total				

Please supply details of any payments made since the incident

Week Ending	Gross Pay	Income Tax	Employees National Insurance Contribution	Net Pay
Total				

Has any claim been made on behalf of the injured party either verbally or in writing?

Yes No

IMPORTANT All correspondence received should be forwarded immediately, unanswered. (it is in order to supply insurance details to the claimants representative)

Make no admission of liability or promise of payment.

N.B Some or all of the information which you supply to AXA Insurance /Faraday Reinsurance in connection with this insurance will be held by the Company on computer and may be passed on to other insurance companies for underwriting and claim handling purposes.

Declaration I/we declare that the information given on this form is true to the best of my/our knowledge and belief. I/we authorise you and your solicitors to deal with this claim within the terms of my/our policy and admit liability on my/our behalf if appropriate.

Signature Date