

EMPLOYERS LIABILITY CLAIM FORM

Broker Ref:

Policy No:

POLICY HOLDER	
Name	
Address	
Postcode	
Occupation	
Contact telephone number	
Are you registered under the VAT Regulations – if yes please provide details	

EMPLOYEE	
Name	
Address	
Postcode	
Date of birth	
Occupation	
National Insurance No	
Length of employment with company	
Is he/she a direct employee	
Average weekly wage	

INCIDENT	
Date & time	
Location	
Full description of the accident	
What task was the employee carrying out at the time of incident	

INCIDENT continued	
Nature and extent of injury/disability	
Did the employee attend hospital	
Has the employee resumed work	
Is he/she carrying out their normal duties	
To whom was the incident reported – please provide date and time	
Has the incident been reported to the Health & Safety Executive	

WITNESSES	
Name/s	
Address/s	

I/We declare to the best of my/our knowledge and belief that the details given on this form are true, I/We understand that you may seek information from other Insurers to check the answers that I/we have provided.

Signature of Policyholder _____ **Dated** _____

Please return this form to: Bradshaw Bennett Ltd, Catherine House, Catherine Street, Macclesfield, Cheshire SK11 6BB

Insurers pass information to the claims and underwriting exchange register run by Insurance Database Services Ltd (IDS Ltd) and Motor Insurance Anti-Fraud and Theft Register run by the Association of British Insurers (ABI). The aim is to help us check information provided and also to prevent fraudulent claims. Under the conditions of your policy you must tell us about any incident (such as accident or theft) which may or may not give rise to a claim. We will pass information relating to this incident to the Registers.