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## Employers Liability Claim Form

### YOUR DETAILS

Policyholders Name(s)			
Policy No.			
Address			
	Postcode		
Trade or Business			
Telephone (Inc. STD)			
Person to Contact			

### DETAILS OF EMPLOYEE(S)

Name							Age			
Address										
	Postcode									
Telephone (Inc STD)										
Occupation / Department							Start Date			
Nat Ins No.							Clock/Work No			
Is the employee either a direct employee or a labour only sub-contractor? If 'Yes' please provide details										Yes / No
Was the employee actually in the course of their employment? If 'No' please give details										Yes / No
Is the employee married, widowed, single or have a partner? Number of dependent children?										
Did the employee have any physical defect or relevant medical history before the accident? If 'Yes' please give details										Yes / No

### INCIDENT DETAILS

Date & Time of incident							am/pm			
Where did incident occur?										
What was the nature of the work being performed?										
State length of experience in carrying out this type of work.										
Was the accident connected to machinery?										Yes / No
Was the machinery guarded?										Yes / No
Give details of any breach of Instructions										

**NO ALTERATION SHOULD BE MADE TO SUCH MACHINERY WITHOUT OUR CONSENT**

Has the accident been entered in your record book or on form F2509 in accordance with the Notification of Accident?										Yes / No
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**If 'yes' please attach a copy of the entry together with forms F2058 (Notifiable Diseases) and BI 76 as soon as available**

Has HM Factory Inspector/Health & Safety Executive/Local Authority investigated since the incident?										Yes / No
Has there been a warning of prosecution?										Yes / No
Has there been any breach of the Factories Act, the health and safety at work act or any other regulations?										Yes / No
If 'Yes' please give details. Indicate the Name and Position of person in authority over the injured employee										

***INJURY OR DISEASE***

Name of injury or disease.		Date reported.	20
Cause of injury or disease.			
If a disease, state alleged period of exposure.			
If employee was medically examined or removed to hospital give particulars (attach copies of any Medical Certificates received)			
When did employee (a) Leave work?		20	
(b) Return to work?		20	
If not yet returned when is he/she expected to return?		20	
If accident resulted in death either at the time or subsequently give date of death		20	

***WITNESSES***

Name(s)	Address(es)	Tel. No.

***DESCRIPTION OF ACCIDENT / MACHINERY***

Please state how accident happened and where helpful draw a diagram or sketch.

Use a separate sheet if necessary.

Where machinery plant or equipment was involved, use illustrated brochures or photos if available.

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***DECLARATION***

I/We declare that the foregoing statement is a true account to the best of my/our knowledge and belief.

Signature(s)

Position

Date

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