EMPLOYERS' LIABILITY CLAIM FORM

Please complete this form as fully as possible. If there is insufficient space please use a separate sheet of paper.
If the claim is for Agricultural Wages Compensation it will be necessary to also complete a supplementary form.

ABOUT THE POLICYHOLDER

Name of Policyholder		Policy No.	
Address		Tel. No.	
		Email	
Occupation			

ABOUT THE INCIDENT

Where did it occur?			
On what date?		At what time?	
Describe what happened			
Give name and address of any witnesses to the incident			
What is the relationship, if any, of the witnesses to the Policyholder and/or the third party?			
Where was each witness at the time of the incident?			

Please provide a copy of the entry in the Accident Book, as well as copies of any statutory reports that were completed.

INJURY TO AN EMPLOYEE

What is the name of the employee?

What is the address of the employee?

Date of birth.

National Insurance Number

What is the nature of the work carried out by the employee?

Full or part time?

How long employed by you?

Has the employee been absent from work as a result of this incident?
If yes state the period of absence.

Employee's net weekly wage per week

or net monthly salary per month

Did the employee receive first aid treatment at the workplace?
If yes, give details.

Has a claim been made against you, either verbally or in writing?
If so provide details and attach copies of any correspondence.

DECLARATION

I/We declare that the information given on this form is true to the best of my/our knowledge and belief. I/We understand that information may be requested from other parties to check the information that has been given.

Signature

Date

Print name

Position

Farmsure
Underwriters Limited