INSURANCE RISK & CLAIMS MANAGEMENT LTD

Commercial Lines Broker of the Year 2010
Finalist Schemes Broker of the Year 2010

Liability Claim Form

POLICY DETAILS

Policy Number: ______ **Insurer:** ______

POLICYHOLDER

Name: ______

Address: ______

Postcode: ______

ACCIDENT DETAILS

Date: DD/MM/YYYY **Time (24hr Clock):** hr/min

Address / Location: ______

Date reported to you: DD/MM/YYYY **Time (24hr Clock):** hr/min

By Whom: ______

Full description of the accident circumstances. (If you feel a sketch would assist, please attach on a separate sheet.)

______

Do you blame anybody for this accident? Yes No If YES please provide details:

Name & Address: (Including Postcode**)** ______

WITNESS (If practical, witness statements should be obtained at an early stage.)

Name & Address: (Including Postcode**)** ______

Is this witness in your employment? Yes No

Please detail any additional witnesses on separate sheet.

INJURED PARTY OR OWNER OF DAMAGED PROPERTY:

Name & Address: (including Postcode)

Details of Personal Injury: ______

Claim Line – Tel: 01902 796 793 Fax: 01902 796 799
Insurance Risk & Claims Management Limited
Three Charter Court, Broadlands, Wolverhampton. WV10 6TD

ircm
Marine & Specialist

Details of Damage to Property:

If Injured Party is an Employee:

Occupation: **Date of Birth:** DD/MM/YYYY

Is this person directly employed by you? **Yes** **No**

If NO: Is this person employed by a Sub-contractor? **Yes** **No**

If YES: Details of Sub-contractor

Length of time in your employment: Years Months

Average net weekly earnings:

Date first incapacitated, i.e. date absent from work: DD/MM/YYYY

Probable duration of Incapacity: ____________ Months ________________ Days

Name of Doctor or Hospital where injured employee is attending:

Prior to the accident did he / she suffer from any physical disability: Yes / No
If yes, please give details:

Please specify nature of work at time of accident -

Was the person performing a duty for which they were employed? Yes / No
If no, please give details:

Was the work within the company rules & procedures? Yes / No
If no, please give details:

Is anyone to blame for the accident? Yes / No
If so, who and why?

STATEMENT OF WAGES

Please give the following wages information for the 13 week period immediately prior to the accident.

Employee Tax Code:

	Week Ending	Gross Earnings	Tax Paid	National Insurance Contribution	Graduated Pension Contribution	Net Amount Received
1	DD/MM/YYYY					
2	DD/MM/YYYY					
3	DD/MM/YYYY					
4	DD/MM/YYYY					
5	DD/MM/YYYY					
6	DD/MM/YYYY					
7	DD/MM/YYYY					
8	DD/MM/YYYY					
9	DD/MM/YYYY					
10	DD/MM/YYYY					
11	DD/MM/YYYY					
12	DD/MM/YYYY					
13	DD/MM/YYYY					
	Totals					

DECLARATION

I/we declare that to the best of my / our knowledge and belief the foregoing particulars are true in every respect. The information on this form is confidential to Insurers for use by them and their Legal Advisors in the event of a claim arising.

Signature of Policyholder:

Position: Date:

If you have any supporting documentation or correspondence please attach copies and detail any additional information to explain and assist the processing of the claim. Return to your Broker or direct to IRCM as advised by your Brokers