Employers' Liability Claim Form

NIG Commercial Claims P O Box 1151 Bromley BR1 9WB

Please note - you can complete this form on screen. When completing please use the tab and arrow keys to move between the relevant fields. Ensure you do not use the return or enter keys.

If completing by hand, please answer all questions using BLOCK CAPITALS.

1 You the Policyholder

Name of the Insured			
Address			
Town		County	
Postcode		Date Premium Paid	
Occupation		Telephone Number	
Policy Number		Value Added Tax. Are you a registered person or company?	Yes ☐ No ☐

Name of Employee			
Address			
Town		County	
National Insurance No.		Occupation	
Date of Birth		Age	Marital Status

2 General Information

a Was he/she in your employ and pay? Yes ☐ No ☐

b If he/she is in your direct employ were instructions/supervision given by your employees?

Yes ☐ No ☐

c If he/she is employed by or receives instructions/supervision from a contractor to you or persons/company to whom you are contracted, state their name/address

d The following documents are requested:

Pre-action Protocol and Fast Track Discovery — **Tick (✓) appropriate box**

	Enclosed	Available	Not held
1 Accident book entry			
2 First Aider's report			
3 Foreman/Supervisor's accident report			
4 Safety representatives accident report			
5 Riddor report to HSE			
6 Other communications between defendants/HSE			
7 Minutes of Health & Safety committee/meetings where accident/matter considered			
8 Report to DSS			
9 Documents relative to any previous accident/matter identified by the Claimant and relied upon as proof of negligence.			

You should not delay the submission of this form if any of the above are not readily available

2 General Information *continued*

e Date of commencement of employment?

(dd/mm/yyyy)

f For the 52 weeks prior to the accident, please state:

i Gross earnings £

ii Income Tax deducted £

iii N.H.I. benefits deducted £

iv Net Earnings £

Please indicate total number of weeks (if not 52 weeks)

g State total periods of absence in 52 weeks prior to accident divided into causes:

Cause

Period

Paid/Unpaid?

Cause

Period

Paid/Unpaid?

h If employment was of casual nature, state:

i How was he/she being paid

ii What was the weekly average

iii Details of any deductions

iv Payments from any other employers

3 Circumstances of the Claim

a Date of Accident (dd/mm/yyyy) Time am pm

b Place

c When was the accident first reported to you or your representative?

d Describe nature of work being performed at the time of the accident

e Description of the accident

f If the accident involves machinery:

i was it properly guarded? Yes No

ii was the guard in use Yes No

g Has H.M Factory Inspector examined the machinery/premises since the accident?

Yes No

If **yes**, date of examination (dd/mm/yyyy)

h Was the accident caused by negligence? Yes No

i Name and address of negligent person

j Name and address of negligent employers

k Details of the negligence

l Name and position of person in authority over injured employee

Name

Position

3 Circumstances of the Claim *continued*

m Was the injured employee doing the work he/she should have been doing and in the correct way?

Yes ☐ No ☐

If **no**, please give full details

n Names and addresses of witnesses. If employees of yours state their position(s)

i Name

Position

ii Name

Position

iii Name

Position

iv Name

Position

o Nature of the injuries (please give as much detail as possible)

p If removed to hospital or otherwise medically examined state name and address of hospital or doctor

q State date (dd/mm/yyyy) on which employee:

i Left off work

ii Returned to any part of former work

iii If not yet returned, date expected to resume

r Have you received notice of claim? Yes ☐ No ☐

If **yes**, from whom, when and in what form (if claim in writing please forward with this form)

Please do not enter into any correspondence with the injured employee or his representatives. Similarly no payments, offers or admissions of liability are permitted by your policy. Any such action could prejudice the position adversely.

In respect of fatal accidents or serious injuries which may or may not prove fatal, immediate telephone notification is required.

I/We declare these particulars are true and complete in every respect.

Insurers and their agents share information with each other to prevent fraudulent claims and to decide whether to accept your proposal and, if so, on what terms via the Claims and Underwriting Exchange Register, operated by Insurance Database Services Ltd. A list of participants is available on request. The information you supply on this form, together with the information you have supplied on your application form and other information relating to the claim, will be provided to participants.

Signature

Date (dd/mm/yyyy)

Designation of Signatory