

LIABILITY ACCIDENT REPORT FORM



PLEASE COMPLETE ALL QUESTIONS FULLY TO AVOID DELAY IN HANDLING YOUR CLAIM

PLEASE COMPLETE IN BLOCK CAPITALS

E-mail: icci.claims@insurancecorporation.com

P.O. Box 160
St. Peter Port,
Guernsey, GY1 4EY
Channel Islands

Telephone: 01481 713322
Facsimile: 01481 714426

www.insurancecorporation.com

P.O. Box 742
St. Helier,
Jersey, JE4 8ZZ
Channel Islands

Telephone: 01534 700200
Facsimile: 01534 768447

Policy No.

Broker/Agent

Name of Insured Mr, Mrs, Ms, Miss

Address

Postcode

Telephone No. (Home)

Telephone No. (Business)

Occupation

Renewal date / /20

Are you VAT registered? Yes No

Details of accident/loss - complete in all cases

Date of accident / /20 Time am/pm

Where did it happen?
(address of premises and description of site)

When and by whom was it first notified?

What was the nature of the work you (the policyholder) were undertaking at the place of the accident?

State fully what happened to cause the accident? (continue overleaf if necessary)

Give whatever details you can about the extent of injury, disease or damage

Give name(s) of person(s) injured or whose property was damaged

Name

Address

Postcode

Give name(s) of any witnesses to accident

i) Name Telephone No. (if known)

Address

Postcode

ii) Name Telephone No. (if known)

Address

Postcode

Has any claim been made against you? Yes No

Any letter or document you receive should be passed to us immediately and unanswered

Section 3 - Complete only if an employee is injured

Name of employee Age yrs

Marital status Occupation Length of service yrs

Has the employee come back to work? Yes No

If so give date of return / /20 If not off work tick box

Give details of employees **net** weekly wage or **net** monthly salary
a) per week or b) per month

Give details of Statutory Sick Pay/Company Sick Pay, payable per week

All communications relating to the accident must be forwarded immediately unanswered to Insurance Corporation.

I/We declare that the statements made are true to the best of my/our knowledge and belief.

Signature of Insured Date / /

Additional Information

Please use this space to provide any further details.