

LIABILITY INCIDENT REPORT FORM

Please complete this form and return to Sagar Insurances, Group First House, 12a Mead Way, Shuttleworth Mead Padiham, Burnley, BB12 7JU

T 01282 858250 : F 01282 858299: E <u>claims@sagarinsurances.co.uk</u>

If there is insufficient space on the form to respond to questions fully please use a separate sheet of paper

General Information

Insured	Contact details
Name	Daytime phone no
Address	Mobile phone no
Contact name	E mail address
VAT Reg. No	Is rating full, partial
(if applicable)	or exempt
Insurance Details	
Insurance Company	
Policy No	

The Incident

Please keep any broken parts of machinery, plant or equipment or any other relevant item involved in the incident.

Date and time of incident		Place incident	
		occurred	
To whom was the incident		When was it	
first reported		reported	
Circumstances –			
What happened and what wa	as the cause? (please give fu	ll details)	

Witness Details

Give details of any person who witnessed the incident

Name	Address	Where was witness at time of incident	Relationship to injured party or property owner

Employee Details

Complete this section if an employee is injured

	- - <i> </i>			
Name of employee		Date of Birth		
Address		National Insurance		
		Number		
		Is employee full time		
		or part time		
Nature of employee's job		How long has		
		employee held this position		
How long has employee be	l een with company	position		
Has employee been absent	from work as a result of the incident			
If "yes" give dates of absence		From	То	
Give details of employee's net weekly wage		£	per week	
or net monthly salary		£ per month		
Give details of company sick pay due weekly		£	per week	
or monthly		£	per month	
	orm "Report of Injury or Dangerous Oc	currence	Yes / No	
If "yes" please enclose a co	• •			
Have you completed HSE form "Report of a Case of Disease"			Yes / No	
If "yes" please enclose a co	рру			
Was entry made in Accident Book			Yes / No	
If "yes" please enclose a co				
Did employee receive any first aid or other treatment			Yes / No	
If "yes" please give details	of what treatment was administered a	nd by whom		

Details of Injury / Damage / Disease

Give whatever details you can about the extent and nature of the injury / damage or disease

Third Party Details

Complete this section if the person injured was not an employee or where a person's property has been damaged Name of person

Address	

Claim

Any letter or document you receive from an employee or third party should not be answered. It should be passed to us immediately.

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Has any claim been made by, or on behalf of the employee or	Yes / No
third party	
If "yes"	
What date was the claim made	
Who made the claim	
Was it a written or verbal claim	

Declaration

I / We declare the information given is true to the best of my / our knowledge and belief

Signature	Date	
Print name	Position / Job title	

Documentation which may be required following notification of a claim :-

General :-

Internal accident and investigation reports

Witness statements

Sketch plan of accident / incident location

Photographs of the area affected / machine / injury

Risk assessments

If the incident involved a machine or piece of equipment :-

Machine instruction manual or operational guide

Maintenance and inspection records

Routine servicing records

Medical records :-

Accident & Emergency record

First aiders report

Additionally if the incident was an injury to an employee :-

HSE RIDDOR form (F2508 or F2508A)

Wage details

Contract of employment

Training records

Foreman / Supervisor's accident report

Occupational health records

Sickness / absence records (including copies of sick notes)

Previous complaint records

Personnel file (appraisals)

Proof of safety / procedure equipment supplied and / or in use