

**Please return to:**

Claims Department, COBRA Insurance Brokers Ltd  
 Quadrant House, Croydon Road  
 Caterham, Surrey, CR3 6TR

Please complete fully in **BLOCK CAPITALS**

T: 01883 346346 F: 01883 330222 E: claims@cobrainurance.co.uk

<b><u>1. INSURED</u></b>	
a. Name:	
b. Address:	
c. Telephone Number:	
d. Fax Number:	
e. Business/Occupation:	
f. Value Added Tax. Are you a registered person or company?	
g.	
i. Name of Employee	
ii. Address	
iii. National Insurance Number	
iv. Occupation	
v. Marital Status	
vi. Date of Birth	

<b><u>2. GENERAL INFORMATION</u></b>	
a. Was he/she in your employ and pay?	
b. If he/she was in your direct employ were instructions/supervision given by your employees?	
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. Date of commencement of employment:	
e. For the 13 weeks prior to the accident (or lesser period employed) please state:	
i. Gross earnings	
ii. Income Tax deducted	
iii. N.H.I benefits deducted	
iv. Net Earnings	
Please indicate number of weeks employed for (if not 52 weeks)	
f. Please state periods of absence in 52 weeks prior to accident divided into causes/period and whether paid/unpaid	

<p>g. If employment was of a casual nature, state:</p> <ul style="list-style-type: none"> <li>i. How he/she being paid</li> <li>ii. What was the weekly average wage</li> <li>iii. Details of any deductions</li> <li>iv. Payments from any other employees</li> </ul>	
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<b><u>3. CIRCUMSTANCES</u></b>	
a. Date and time (am/pm) of Accident:	
b. Location:	
c. When was the accident first reported to you or your representative?	
d. Describe the nature of the work being performed at the time of the accident:	
e. Describe the accident:	
f. If the accident involves machinery:	
i. Was it properly guarded?	
ii. Was the guard in use?	
g. Was the accident caused by negligence?	
h. Name and address of the negligent person:	
i. Name and address of negligent employers:	
j. Details of the negligence:	
k. Name and position of person in authority over injured employee:	
l. Was the injured employee doing the work he/she should have been doing and in the correct way?	
If no, please give full details:	
m. Names and addresses of witnesses. If employees of yours state their positions:	

# Employers Liability Claim Form

<p>n. Nature of injuries (please give as much detail as possible:</p>	
<p>o. If removed to hospital or otherwise medically examined, state name and address of hospital or doctor:</p>	
<p>p. State the date on which the employee:</p> <p>i. Left of work:</p> <p>ii. Returned to any part of former work:</p> <p>iii. If not yet returned, date expected to resume:</p>	
<p>q. Have you received notice of a claim?</p> <p>If yes, from whom, when and in what form – <b>if claim in writing please forward with this form</b></p>	

**Please do not enter into any correspondence with the injured employee or his/her representatives. Similarly no payments, offers or admission 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.**

Insurance companies maintain a number of anti-fraud and theft registers to help check information and prevent fraudulent claims. Insurers may search these registers as part of their investigations and will pass information relating to this incident to the appropriate register(s) for the future reference of other parties.

<b>4. DECLARATION</b>	
I/we declare that all particulars on this form are true and correct:	
Name: .....	Signature: .....
Status of Signatory: .....	Date: .....

Please complete and return this form to COBRA Insurance Brokers as soon as possible.