Loss of Earnings Form

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

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

Please complete fully in **BLOCK CAPITALS**

a. Employer:	
b. Employee:	
c. Date of Accident:	
d. Location/Department of Employee:	
e. Date ceased work as a result of accident:	
f. Date returned to work following recovery:	
g. National Insurance Number	

A. EMPLOYEE EARNINGS 13 WEEKS PRIOR TO ACCIDENT

Week Ending	1. Gross Pay	2. Income Tax (Refunds)	3. Employee's NI Contribution	4. Other Deductions	5. Net Pay (1-2-3-4)

COBRA™ INSURANCE BROKERS LTD

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B. PAYMENTS RECEIVED DURING PERIOD OF ABSENCE

Week Ending	1. Gross Pay	2. SSP	3. Company Sick Pay	4. Income Tax Refunds	5. Employees NI Contribution	6. Other Deductions	7. Net Pay (1-4-5-6)

DECLARATION

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 along with the Employer's Liability Claim Form.