



PUBLIC LIABILITY CLAIM FORM

(THE COMPANY DOES NOT ADMIT LIABILITY BY THE ISSUE OF THIS FORM)

CLAIMS HOTLINE – 0501447071 / 0501447063

A. POLICYHOLDER DETAILS

Name of Insured: _____

Policy Number: _____

E-mail Address: _____

Postal Address: _____

Telephone No: _____ Business/Occupation: _____

B. DETAILS OF ACCIDENT

1. Date of Incidence: _____ Time: _____

2. Exact place where Accident/Loss occurred: _____

3. Give full details of how the accident occurred: _____

4. Name and Address of the Person who caused the Accident: _____

5. Name and Address of his/her employers: _____

6. Was the Accident caused by any defect in your Premises, Plant or machinery?



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If yes, state exact nature of defect: _____

7. Was the accident caused through or by any of your employees? _____

If yes, state names occupations and how long in your service: _____

8. Describe the work you or your employees were engaged to do at the time of the incidence: _____

9. Name and Address of the Company/Person for whom you were working for and/or under contract: _____

10. Who are the Main Contractors? _____

C. GENERAL INFORMATION

Damage:

11. If the Property of any person other than that of an employee has been damaged, state:

Name and address: _____

Occupations: _____

Description of the property damaged: _____

Nature and extent of the damage: _____



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Where can the damaged property be inspected? _____

12. Has any claim been made upon you? _____

If yes, for what amount? _____

Injury:

13. If any person other than an employee was injured, state:
Names/Age/Addresses/Occupations

14. Nature and Extent of Injuries: _____

15. Name and address of Employer (if any): _____

Date ceased work: _____ Date resumed: _____

16. Name of the hospital to which the injured person was taken to: _____

D. WITNESSES

17. Give the name and address of all witnesses: (indicate if own employee or independent):



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18. Was the incident reported to the Police? _____

If yes, State the Name of the Police Station _____

Name/Telephone Number of Police Officer: _____

19. Have you received notice of the claim? Yes/No _____

20. Have any steps been taken to compromise or settle the matter in anyway?

Yes/No

21. Are there any other policies covering you for this accident? _____

If yes, give details: _____

Any written communication received should be forwarded immediately unanswered.

E. DECLARATION

I/We _____

Position: _____ of the insured and on

behalf of the insured declare the above answers to be true and correct AND

acknowledge that the insurer may make its decision on indemnity having regard

to these answers.

Signature: _____ Date: _____