LIABILITY ACCIDENT REPORT FORM

INSURANCE CORPORATION

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

P.O. Box 742
St. Helier,
Jersey, JE4 8ZZ
Channel Islands
Telephone: 01534 700200
Facsimile: 01534 768447

www.insurancecorporation.com

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.