

Verlingue Employer's Liability Claim Form

Please complete this form and send on to your Claim Handler or the Claims Team.

The Claims Team details are as follows: Email: newclaims@verlingue.com, or by telephone: 0333 010 0013

Section A

Employers name:	
Address:	
Trade / business:	

Section B

Employees name:	
Address:	
Telephone number:	
Date of birth:	
Job title:	

Employment status (please tick as appropriate)

Are you an employee?	Y/N
Are you on a training scheme? If Yes, please provide details.	Y/N
Are you on work experience?	Y/N
Are you employed by someone else? If Yes, please provide details of the other employer.	Y/N
Are you self-employed and at work?	Y/N

Section C

Date of incident:	
Time of incident:	
Did the incident happen at the employers address as shown above? If No, please confirm below where the incident happened:	Y/N
a. Elsewhere in the organisation	Y/N
b. At someone else's premises	Y/N
c. In a public place	Y/N

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Section C

Please give details of name, address, postcode and where it happened

Were there any Witnesses?

If Yes, please provide full names and addresses.

Witness 1

Witness 2

Witness 3

Section D

What was the injury (e.g., fracture, laceration)?

What part of the body was injured?

Was the injury... (tick one box only)

- | | |
|--|-----|
| a. A fatality | Y/N |
| b. A major injury or condition | Y/N |
| c. An injury to an employee or self-employed person, which prevented them doing their normal work for more than 3 days | Y/N |

Did the injured person (tick as appropriate)

- | | |
|--|-----|
| a. Become unconscious | Y/N |
| b. Need resuscitation | Y/N |
| c. Remain in hospital for more than 24 hours | Y/N |
| d. None of the above | Y/N |

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Section E

**About the kind of accident, tick the appropriate box and then proceed to the description.
Only select the box that best describes the incident.**

Contact with moving machinery or material being machined.	Y/N
Hit by a moving, flying or falling object.	Y/N
Hit by a moving vehicle.	Y/N
Hit something fixed or stationary.	Y/N
Injured while handling, lifting or carrying.	Y/N
Slipped, tripped or fell on the same level.	Y/N
Fell from height – how high was the fall in metres.	Y/N
Trapped by something collapsing.	Y/N
Drowned or asphyxiated.	Y/N
Exposed to, or in contact with a harmful substance.	Y/N
Exposed to fire.	Y/N
Exposed to explosion.	Y/N
Contact with electricity or an electrical discharge.	Y/N
Injured by an animal.	Y/N
Physically assaulted by a person.	Y/N

Section F

I/we declare that the above statements are true and correct to the best of my/our knowledge and belief.

I/we agree to provide insurers with any further information as they may reasonably request.

I/we understand that Verlingue Limited do not admit liability by the issue of this claim.

Name:	
Position:	
Signature:	
Date:	