Employers Liability Report Form

Completing the claim form

It is always important to notify your Insurer of a claim as soon as possible after an accident has occurred. Please therefore complete this form and return it to us within thirty days of the incident. We will then forward all relevant information and documentation to your Insurer.

Contact our Claims department or your Account Executive on the following numbers if you require any assistance with completing this form.

PLEASE COMPLETE ALL RELEVANT SECTIONS USING BLOCK CAPITALS.

Tick the boxes and sign and date the form

Claims Department Contact Numbers

Andrea Compton	0116 2999 071
Kally Toft	0116 2999 016
Matthew Thompson	0116 2999 020

Directors/Account Executives

Chris Thorpe	0116 2999 009
Dave Norwood	0116 2999 015
James Moore	0116 2999 019
Ketan Popat	0116 2999 064
Jo Watson	0116 2999 003
Perry Turner	0116 2999 002
Peter Turner	0116 2999 005

Third Party Correspondence

All correspondence received from other parties relating to the incident should NOT be answered but sent to us immediately.

Should I make a claim?

All incidents should be advised to the Company whether or not it is your intention to make a claim against your policy.

Complaints Procedure

We will endeavour to deal with all aspects of your insurance requirements in a professional manner. Should you not be satisfied with any aspect of our service, you should refer the matter initially to your account executive. If you remain unsatisfied, you may request that a review of your case be conducted by the partners of Turner Insurance Group. Your complaint will be acknowledged in writing within five days and the investigation completed within fourteen days of your request and a written reply submitted to you. If you are a retail customer as defined by the Financial Services Authority and are still not satisfied you can take your complaint to the Financial Ombudsman Service. Details are available on request.

Employers Liability Report Form

For office use only Turners Claim Reference _____

Insurance Company _____

POLICYHOLDER

Name/Insured			
Policy number			
Address			
Postcode			
Business			
Daytime telephone number		Contact	
Fax number			
E-mail address			

ACCIDENT/INJURY

Date		Time		am/pm
Location				
When was it first notified to you?			By whom?	
Has a record of the accident been made? (if YES attach copy)			Yes ☐ No ☐	
State fully what happened (continue on a separate sheet if necessary)				
Has any similar occurrence previously taken place? (If YES give details)			Yes ☐ No ☐	
What precautions against the accident/injury had previously been taken?				
What plant or equipment, if any, was involved? (any relevant equipment must be kept for inspection)				
Was it properly guarded? Yes ☐ No ☐		Was guard in use?	Yes ☐ No ☐	
Has any Authority investigated since the event? (If YES give details)				
Name & Addresses of all witnesses (if written statements obtained, please attach)				
Name of Person in charge at the time				
If an Accident was caused by a person **not** in your employ, state their and their employers' name and address				
Name & Place of any hospital to which injured person taken				

EMPLOYEE

Name		Date of Birth	
Address			
		Postcode	
Occupation		National Ins. No.	
Is he/she in your direct employ?	Yes ☐ No ☐	For how long?	
State length of experience In this type of work			
State any physical defect or relevant medical history prior to the event			
Date employee ceased work		Date of return	

EMPLOYEES WAGE DETAILS (if applicable)

Please give details of injured employees earnings for thirteen weeks prior to the accident

Week Ending	Gross Pay	Income Tax	NI Contributions	Supplements	Net Pay after Tax & NI

Please give details of any payments made to the employee since the accident

Wages (net)	£
Statutory sick pay	£
Other Payments (give details)	£

DECLARATION

I declare that these details are correct to the best of my knowledge.			
Signature of Policyholder		Date	
ANY CORRESPONDENCE THAT YOU RECEIVE ABOUT THIS INCIDENT SHOULD NOT BE ANSWERED BUT SENT TO US IMMEDIATELY			

Employers Liability Loss of Earnings Form

Employer	
Employee	
Policy Number	
Accident Date	
Date ceased work following accident	
Date returned to work following recovery	

EMPLOYEES WAGE DETAILS

Please give details of injured employee's earnings for thirteen weeks prior to the accident

Week Ending	Gross Pay	Income Tax	NI Contributions	Supplements	Net Pay after tax & NI

Please give details of any payments made to the employee since the accident

Wages (net)	£
Statutory sick pay	£
Other Payments (give details)	£