

Claim Form - Liability

At Intasure we appreciate how stressful a claim can be and we aim to make the process as quick and painless as possible. Please remember to attach any documents, accounts or original purchase receipts in order that we can deal with your claim as promptly as possible. If you require any assistance in completing this form then please do not hesitate to contact the **Claims Team** on **+44 (0)345 073 7147** between 9am and 5pm Monday to Friday.

SECTION 1 - Details of Policyholder and Policy

Name	Policy No.
Address	Renewal Date: <input type="text" value="DD"/> <input type="text" value="MM"/> <input type="text" value="YY"/> <input type="text" value="YY"/>
<input type="text" value="Postcode"/>	Name of Official to be contacted in connection with this accident:
Email Address	Are you registered for VAT? <input type="checkbox"/> NO <input type="checkbox"/> YES
Home Tel	Policyholder Trade or Occupation:
Mobile Tel	

SECTION 2 - Accident / Incident

a. Section 2a applies to Employer's, Public, Product and Property Liability Claims

Address where accident / incident / damage occurred:	Injured Person Name:
<input type="text" value="Postcode"/>	Address:
Date of accident/incident/damage: <input type="text" value="DD"/> <input type="text" value="MM"/> <input type="text" value="YY"/> <input type="text" value="YY"/>	<input type="text" value="Postcode"/>
Time of accident/incident/damage: <input type="text" value="AM / PM"/>	Age:
	On what date did you receive notice of accident/incident/damage AND from whom: <input type="text" value="DD"/> <input type="text" value="MM"/> <input type="text" value="YY"/> <input type="text" value="YY"/>

For a **Property Damage Claim** - Was someone else responsible for the incident damage? NO YES

Give a full description of the accident / incident / damage and state exactly how it occurred:

Name, address and contact telephone numbers of all witnesses to accident / incident, and in the case of a public liability claim state by whom employed:

SECTION 2 - Accident / Incident (continued)

b. Section 2b applies to Employer's, Public and Product Liability claims only

Details of injury: What was the injury? (e.g. fracture, laceration, bruising, etc):	First Aid treatment provided?: <input type="checkbox"/> NO <input type="checkbox"/> YES
	Name of First Aider:
	Contact number:
What part of the body was injured? (e.g. head, leg, finger, etc):	

c. Section 2c applies to Employer's, Public and Product Liability claims only

What lost time was incurred by the accident / incident: (please tick appropriate box)

No injury (near miss) <input type="checkbox"/>	Reported back to work <input type="checkbox"/>	Off work for 3 days or less <input type="checkbox"/>
Off work for more than 3 days <input type="checkbox"/>	Deployed on light duties <input type="checkbox"/>	Hospitalised <input type="checkbox"/>

SECTION 3 - Reporting Injuries - e.g. fractures, unconsciousness, dislocation; Hospitalised for more than 24 hours; over 3 days absence, including rest days, not including the day of the accident; Dangerous Occurrence, e.g. truck overturning)

For Employer's, Public and Product Liability claims only

Is the accident / incident reportable? <input type="checkbox"/> NO <input type="checkbox"/> YES	Has the accident / incident been reported? <input type="checkbox"/> NO <input type="checkbox"/> YES
Date of report: <input type="text" value="D"/> <input type="text" value="D"/> <input type="text" value="M"/> <input type="text" value="M"/> <input type="text" value="Y"/> <input type="text" value="Y"/> <input type="text" value="Y"/> <input type="text" value="Y"/>	Report reference number:

(Telephone No. of HSE Incident Contact Centre, Caerphilly: 0345 300 9923)

SECTION 4

For Employer's and Public Liability claims only

Has the accident been reported to the Police? <input type="checkbox"/> NO <input type="checkbox"/> YES	Do you accept responsibility for the accident? <input type="checkbox"/> NO <input type="checkbox"/> YES
Name of Police Officer:	If not, who do you consider responsible and why?
At what station:	
What work were your employees engaged upon?	
Was the work being carried out under contract? <input type="checkbox"/> NO <input type="checkbox"/> YES	

N.B. A copy of relevant contract may be required by insurers as part of their investigations.

For Product and Property Liability claims only

Has the accident / incident been reported to the Police? <input type="checkbox"/> NO <input type="checkbox"/> YES	Do you accept responsibility for the accident/incident? <input type="checkbox"/> NO <input type="checkbox"/> YES
Name of Police Officer:	If not, who do you consider responsible and why?
Has the accident / incident been reported to the Fire Service? <input type="checkbox"/> NO <input type="checkbox"/> YES	
Name of Fire Officer:	
At what station:	

SECTION 5 - Other relevant factors (e.g. weather conditions; wet floors; obstacles; poor lighting etc)

N.B. TAKE MEASUREMENTS AND PHOTOS AND RETAIN ANY EQUIPMENT ALLEGED TO HAVE BEEN INVOLVED

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VEHICLE REGISTRATION OR SERIAL NUMBER (Where applicable):

SECTION 6

For Product and Property Liability claims only

Please identify product / property involved (to include the model and serial no.)
Model:
Serial No:
Product:

Any explanation literature or brochures concerning product/property would be helpful to insurers.
Do you manufacture the product? <input type="checkbox"/> NO <input type="checkbox"/> YES
If not, please advise name and address of manufacturer:

Was the product supplied with any special instructions for use? <input type="checkbox"/> NO <input type="checkbox"/> YES
<i>If it is considered that a failure to comply with such instructions has contributed to or caused the accident, please forward a copy of the relevant instructions.</i>
Has the product been returned by the Claimant and / or supplier for testing? <input type="checkbox"/> NO <input type="checkbox"/> YES
If so, please provide a copy of any technical report prepared.

Did you supply the product direct to Claimant(s)? <input type="checkbox"/> NO <input type="checkbox"/> YES
If not, please advise name and address of intermediary to whom you supplied product:

Do you accept an allegation of faulty manufacture of your product? <input type="checkbox"/> NO <input type="checkbox"/> YES
Do you accept an allegation of faulty design to your product? <input type="checkbox"/> NO <input type="checkbox"/> YES
(NB. Please ensure that you retain the product in question).

SECTION 7 - Documents attached (Please attach as many of the following documents as possible):

Employer's and Public Liability claims only

(Please tick appropriate box(es))

Copy of a accident book entry	<input type="checkbox"/>	Relevant training records	<input type="checkbox"/>	Risk assessment(s)	<input type="checkbox"/>
Witness statement(s)	<input type="checkbox"/>	Photographs	<input type="checkbox"/>	Sketch / Measurements	<input type="checkbox"/>
Service records	<input type="checkbox"/>	Statement from injured party	<input type="checkbox"/>		

OTHER (Please specify):

Product and Property Liability claims only

(Please tick appropriate box(es))

Statement from injured party	<input type="checkbox"/>	Sketch / Measurements	<input type="checkbox"/>	Witness statement(s)	<input type="checkbox"/>
Photographs	<input type="checkbox"/>	Service records	<input type="checkbox"/>		

OTHER (Please specify):

SECTION 8 - To be completed for Claim(s) involving Damage to Property

This section applies to Property Liability claims only

Are you the owner? NO YES

If "NO" state name and address of the owner:

Name:

Address:

Give the name(s) of any other party having an interest in the property.

Are there any other insurances on the property? NO YES

If "YES" give details (including name, address and policy no. of other insurers)

Name:

Address:

Policy No:

Details:

State total value of insured property:

Building £ Stock £

Other Property £

State Nature of occupancy of premises:

Are you responsible by agreement for the property? NO YES

If "YES" please forward a copy of the agreement.

Have you ever before made a claim of this nature on any insurance company or underwriter? NO YES

If "YES", give details:

Nature of claim:

Date of loss:

Name of Insurers:

Amount paid £

SECTION 9- Notification of Claim

Has any claim been made upon you to date? NO YES

If so, please state when and whether verbally or in writing (if in writing attach a copy of the letter)

SECTION 10- Investigating Manager

For Product and Property Liability claims only

Print Name:

Job Title:

Signature:

Date:

SECTION 11 - Notice

Please note that insurers pass information to the Claims and Underwriting Exchange register, run by Insurance Database Services Ltd (IDS Ltd).

The aim is to help us to check information provided and also to prevent fraudulent claims. When you tell us about an incident (such as fire, water damage or theft) which may or may not give rise to a claim, we will pass information relating to it to the register.

In assessing claims made insurers may also undertake checks against publicly available information as necessary such as electoral roll, county court judgements, bankruptcy orders or repossessions.

Some of the information which you give us about this claim may be passed to other insurance companies you tell us about. They will give us information about your policy with them, and we may ask them to pay a contribution to this claim. A contribution payment is normal practice where two or more policies cover the same thing. If another company contributes to your claim with us, it should not affect any no claim discounts you may have with them.

The currency applicable to the Intasure Home contract is Sterling or Euros as per your schedule. There may be occasions when we need to convert from Sterling to Euros or Euros to Sterling. In such circumstances we will convert using the Barclays Bank plc commercial Exchange Rate on the day a claims payment is made under this policy.

SECTION 12 - Declaration

N.B. Any communication that you receive about the accident should not be answered, but sent to Us or the Underwriters immediately.

I/we understand that you may ask for information from other insurers to check the answers I/we have provided.

I/we declare that the statements made are true to the best of my/our knowledge and belief and I/we have no other insurance which will respond to this claim.

Date

Signature(s) of Policyholder(s)

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THIS FORM SHOULD NOW BE RETURNED TO: Intasure, Oakhurst House, 77 Mount Ephraim, Tunbridge Wells, Kent, TN4 8BS, United Kingdom or email it to claims@intasure.com