MATHEWS COMFORT
est 1851.

Employers Liability Incident Notification Form

Please complete Policyholder, Event and Property Sections. Only complete the relevant section(s) of Details of Claim

Policyholder

Policy No.

Policyholder's Address

Policyholder's Name or Title

Contact Email

Telephone Number

Daytime | Mobile

Occupation

Are you registered for V.A.T? ☐ Yes ☐ No

If **Yes** please give details

Risk Address: (If different from correspondence address)

Employee Details

Name

Address

Date of Birth

Job description

Length of employment

Details of injury/accident/incident (Including site location and time of incident)

National Insurance

Is the employee a direct employee? ☐ Yes ☐ No

Has the incident been reported to the Health & Safety Executive? ☐ Yes ☐ No

Nature and extent of Injury. (Please include if employee received medical treatment on site or at hospital)

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Policyholder

Address

Policy No.

Business description

Employee Details

Name

Address

Date of Birth

Job description

Length of employment

Details of injury/accident/incident (Including site location and time of incident)

Is the employee a direct employee? ☐ Yes ☐ No

National Insurance

Nature and extent of Injury. (Please include if employee received medical treatment on site or at hospital)

Has the incident been reported to the Health & Safety Executive?

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Have HSE carried out an investigation? ☐ Yes ☐ No

If **Yes** – please include report or state "to follow".

Was the employee off work as a result of this incident ? ☐ Yes ☐ No

To whom and when did the employee report the accident?

Has the employee resumed work? ☐ Yes ☐ No
Please provide details of date

If not what is the expected duration of incapacity?

Was the incident recorded in the company accident report book? (Please supply a photocopy of the entry)

Did anyone witness the incident? ☐ Yes ☐ No

Witnesses names and addresses (Please supply a separate document with this information if necessary)

Wages details: please supply details of wages paid to the employee 13 weeks prior to the incident and 6 weeks after.
(Please supply a separate document with this information if necessary)

Signature of Policyholder

Date

Please state position in company

Please return this form as soon as possible together with any correspondence received from the claimant or anyone acting on behalf of the claimant. Acknowledgement of correspondence can be sent from the Insured, but your Insurers will contact the claimant or his/her representative upon receipt of this claim notification. It is strongly recommended that any acknowledgement you send should not enter into acceptance or denial of liability.

Please return this form to:

Mathews Comfort, 6a St Aldates, Oxford, OX1 1BS