

NOTICE OF ACCIDENT – PUBLIC LIABILITY INSURANCE
EACH OF THESE QUESTIONS MUST BE ANSWERED COMPLETELY

(This form is NOT to be used for vehicle accidents)

NOTE: This form should be completed and returned to us as soon as possible, whether or not a claim is being made.

(DO NOT DISCLOSE THAT YOU ARE INSURED)

POLICY NO.: _____ CLAIM NO.: _____

Insured _____

Address _____

Occupation/Business _____

Telephone No _____

E-mail Address _____

1. State carefully:

Date of Accident _____ mm/dd/yy Time _____ a.m./p.m.

Place where accident occurred _____

2. Give full details of how accident occurred

3. Give Names and Addresses of all Witnesses

(State if witness is an employee or an independent witness)

4. At the time of the accident what work were you or your employees engaged to do?

Name and Address of person who caused or who was to blame for the accident

Name and Address of person's Employer if not you

5. Were particulars taken by the Police?

If "YES", give Name and Number of Officer and Address of Police Station

6. Do you have any other Policies covering you for this accident?

If "YES", give particulars

PARTICULARS OF POSSIBLE CLAIMANT

7. Name

Address

State nature of injury or damage

8. Have you received notice of a claim ?

If "YES", from whom and in what form?

Date notified

mm/dd/yy

If claim is in writing please forward with this form

I/We the undersigned, do hereby declare that, to the best of my/our knowledge and belief, the foregoing particulars are true and correct.

Signature of Insured/Claimant

Date

If Company Please Affix Company Stamp

mm/dd/yy