

Liability Accident Report Form

PLEASE COMPLETE ALL QUESTIONS FULLY TO AVOID
DELAY IN HANDLING YOUR CLAIM

PLEASE COMPLETE IN BLOCK CAPITALS

Intact Insurance Isle of Man Limited

P.O. Box 27
Jubilee Buildings,
1 Victoria Street,
Douglas,
Isle of Man, IM99 1BF
Tel: 01624 645900

Email:
intactIOM@intactinsurance.co.uk
www.intactinsurance.co.im

Policy No.

Broker/Agent

Section 1 - Insured Details

Mr/Mrs/Ms/Miss/Other

Name

Postal Address

Postcode

Telephone No. (Home)

Telephone No.

(Business)

Renewal date

Occupation

Are you VAT registered?

Yes

No

Section 2 - Details of accident/loss - complete in all cases

Date of accident

Time

Where did it happen? (address of premises and description of site)

When and by whom was it first notified?

What was the nature of the work you (the policyholder) were undertaking at the place of the accident?

State fully what happened to cause the accident? (continue overleaf if necessary)

Give whatever details you can about the extent of injury, disease or damage

Give name(s) of person(s) injured or whose property was damaged

Name

Postal Address

Postcode

Give name(s) of any witnesses to accident

i) Name

Postal Address

Postcode

Telephone No. (if known)

ii) Name

Postal Address

Postcode

Telephone No. (if known)

Has any claim been made against you?

Yes

No

Any letter or document you receive should be passed to us immediately and unanswered

Section 3 - Complete only if an employee is injured

Name of employee

Age (years)

Marital status

Occupation

Length of service

Has the employee come back to work?

Yes

No

If so give date of return

If not off work tick box

Give details of employees **net** weekly wage or **net** monthly salary

a) per week

or b) per month

Give details of Statutory Sick Pay/Company Sick Pay, payable

per week

All communications relating to the accident must be forwarded immediately unanswered to Intact Insurance Channel Islands Limited.

I/We declare that the statements made are true to the best of my/our knowledge and belief.

Signature of insured

Date

Additional Information

Please use this space to provide any further details