**EMPLOYER’S LIABILITY ACCIDENT REPORT FORM**

***In the event of a claim or incident, please notify your insurance broker.***

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Policyholder Information | | | | | | | | | |
| Policy Number |  | | Name of Insured | | | | |  | |
| Address |  | | | | | | | | |
| Contact Name |  | | | | | | | | |
| Phone number |  | | Email Address | | | |  | | |
|  | | | | | | | | | |
| Employee Information | | | | | | | | | |
| Name of Employee |  | | | | | | | | |
| Date of Birth |  | | NI Number | | |  | | | |
| Occupation |  | | | | | | | | |
| Address |  | | | | | | | | |
|  | | | | | | | | | |
| Accident Information | | | | | | | | | |
| Date of Accident |  | | Time of Accident | | | | |  | |
| Place of Accident |  | | | | | | | | |
| Name of Supervisor |  | | | | | | | | |
| Nature of Injury/Disease |  | | | | | | | | |
| Date of Ceasing Work |  | | Date of Returning to Work | | | | | |  |
| Circumstances of accident/disease (if necessary, please continue overleaf): |  | | | | | | | | |
| If the accident/disease caused by any other party, please provide details: |  | | | | | | | | |
| **In addition to the accident description, please provide copies of:**  **• Accident Book Entry • Any Statutory Health & Safety Notification • Internal investigation report • RIDDOR** | | | | | | | | | |
| Completed by | | | | | | | | | |
| I confirm that the information contained in this form is true and complete to the best of my knowledge.  (THIS FORM MUST BE SIGNED BY A DIRECTOR.) | | | | | | | | | |
| Name | |  | | | | | | | |
| Signature | |  | | Date |  | | | | |

**Your insurance broker will need to pass the completed form onto Sutton Specialist Risks Ltd.**