

Employers Liability

Report Form



With reference to your recent notification of an accident to an Employee, please complete and return this form to the address overleaf as soon as possible.

It is to be completed by the Employer and not handed to the Employee.

If any communication relating to this accident is received from or on behalf of the injured Employee, please pass it to us unacknowledged without delay.

No payment or promise of payment should be made and liability should not be admitted without our authority.

Ref No 90/ /

For All Claims, please complete this section

1. Insured

Name: Telephone No.'s Home:
Policy Number: Business:
Address:

Are you registered for VAT? Yes No VAT Reg No.

Please state actual amount of wages paid to all employees in the 12 months prior to the last Renewal Date of the policy.

The information should be split into the following categories:

Description of all employees	Estimated Number		Actual wages, salaries and other earnings paid in the 12 months prior to the Renewal Date of the policy (wages but not fees of working directors should be included)
	full time	part time	
Clerical, Managerial, Sales Representatives & Commercial Travellers (non manual work)			€
Persons using woodworking machinery			€
Apprentices and persons employed under Employment Training Schemes			€
Other persons working away from your Premises but in the Republic of Ireland (Specify Nature of Work)			€
Any person working manually outside the Republic of Ireland - (Specify Nature of Work)			€
Labour only - Sub-contractors			€
All other (give full descriptions)			€
TOTAL			€

2. Employee

Full Name:

Address:

Occupation:

Status: Married
Single
Age

4. Notification and Witnesses:

a) To whom was the accident first reported and when?

b) Give name, address and occupation of any person who witnessed the accident:

c) If accident was not witnessed, give reason (if any) for supposing it arose out of and in the course of employment:

d) Was entry made in accident book?

Yes No

If 'Yes', please supply copy of entry made in the accident book

5. Injuries:

a) What injury did the Employee sustain?

b) Did he receive medical attention?

Yes No

c) If 'Yes', from whom?

d) When did he cease work?

Date

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Time

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 am/pm

e) Is he detained in hospital?

Yes No

f) If 'Yes', give name of hospital:

g) Is he totally disabled?

Yes No

h) How long is he likely to be totally disabled?

From

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To

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i) State whether he has resumed light or full duties:

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j) If he has returned to work, give date of return:

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6. Disease: (alternative to Section 3)

State nature of disease:

To what is it attributed, i.e. nature of substance, material or irritant?

Was he asked if he had ever suffered from this complaint on entering into your employ?

Yes No

Has he had any previous attacks while in your employ?

Yes No

Date on which you were notified of the disease:

Date on which the Employee ceased working:

What is the nature of the work on which he has been engaged?

For what period has he been so engaged?

From:

To:

Has he received treatment for the disease on your premises?

Yes No

Have any other Employees suffered from the same disease during the past 3 years?

Yes No

Are there any special precautions taken at your premises to prevent this particular disease?

Yes No

If 'Yes', give details"

7. Claim

Has any claim been made by or on behalf of the injured Employee?

Yes No

If 'Yes', by whom was the claim made? Name and Address:

Was claim:

Written:

Verbal:

Date of claim

(All correspondence received should be forwarded with this form)

Declaration

I/We hereby declare that the statements on this form and the information provided in addition are true and complete, to the best of my/our knowledge and belief.

Signature(s)

Date

