Noyce Insurance Solutions Ltd
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EMPLOYER'S LIABILITY CLAIM FORM

POLICY HOLDER	
Name	Policy No.
Address	
Postcode	Tel No
Business	
If registered under VAT regulations please advise status	

EMPLOYEE DETAILS		
Name of Employee	Occupation	Age
Address		
Is he/she in your direct employ?	National Insurance No	
How long in your employ?	Average net weekly wage	

DETAILS OF ACCIDENT		
Date	Time	Place
Describe what the employee was doing and how the accident happened		

Nature and extent of injury/disability

Has the accident been reported to the Health and Safety Executive?
Have they carried out an investigation?

Has the Employee resumed work?	If so when?
If not, what is the expected duration of the incapacity?	

To whom and when did the Employee report the accident?

WITNESSES
Give name and addresses

Employer's signature	**Date**
Name	