Allianz

Appendix 8
Employer's Liability Accident Report Form

Claim No. ______________________

Employer

Name and Business Address of Employer

Email:

Policy Number: ______________________

Date of last premium payment: / /

Business of Occupation:

Telephone Number:

Office Mobile:

Are you registered for VAT? Yes ☐ No ☐ If YES, state registered number: ______________________

Injured Person

Name and Address of Injured Person

Date of Birth: / /

Marital Status:

Occupation:

National Insurance No.:

If the injured person is related to you please state:-

(a) the relationship (a) ______________________

(b) whether he/she resides with you

(b) ______________________

Was the injured person in your direct employment? Yes ☐ No ☐

If YES, state how long in your employment

____

If NO, state name and address of Contractor.

Has employee applied for Occupational/Industrial Injuries Act Benefit? Yes ☐ No ☐

Details of Accident

Date and Time of accident: / / ______________________

Address where accident occurred:

When and to whom was the accident reported by the injured person?

____

Did the injured person cease work? Yes ☐ No ☐

If YES, state the date on which he/she did so / /

Please continue overleaf →

If the injured person has resumed work, state the date on which he/she did so. __ / __ / ____

Was the injured person engaged on work for you at the time of the accident? Yes ☐ No ☐

State fully the nature of work upon which the injured person was engaged at the time of the accident.

Are any specialised tools or equipment required to carry out the work? Yes ☐ No ☐

If YES, give details.

Were any safety features breached? Yes ☐ No ☐

State the date of last inspection by factory inspectorate, and whether or not any recommendations were made.

__ / __ / ____

Give full details of the circumstances and cause of the accident. State through whose fault (if any) the accident occurred?

Injuries

Give full details of injuries received.

Was the injured person taken to hospital? Yes ☐ No ☐ If YES, state name of the hospital

Is the injured person at present receiving medical attention? Yes ☐ No ☐

Claim Details

Has a claim for compensation been made upon you? Yes ☐ No ☐

Is compensation being claimed or received by the injured person from any other source? Yes ☐ No ☐

Has the injured person been injured previously, or received compensation previously, from you or any other employer? Yes ☐ No ☐

Earnings

State the net weekly earnings of the injured person.

State the total net weekly earnings including bonuses, overtime, allowances etc.
of the injured person for the thirteen weeks prior to the accident.

State how many employees are in your service, and the amount of annual cash wages paid to them.

State names and addresses of all people working in the vicinity at the time of the accident. (Enclose statements where possible).

Please continue overleaf →

Data Protection Act - Statements and Consents

Allianz p.l.c. is a member of the Allianz Group, and shall be the data controller in respect of all personal information provided on this form. References to We and Us in these statements and consents shall be construed accordingly. Allianz p.l.c. is regulated by the Financial Regulator.

By your signature you warrant and represent to Us that in respect of any personal data of any data subject which you provide to Us, you have the authority of that data subject to disclose such data to Us and by your signature, consent to all of the information being used, processed, disclosed and retained for the purposes of insurance administration (including underwriting, processing, claims handling, reinsurance and fraud prevention). We will not retain any personal information for longer than is necessary for the purposes for which it is obtained.

We may share with our agents and service providers, members of the Allianz Group, other insurers and their agents, and with any intermediary acting for you, and with recognised trade, governing, and regulatory bodies (of which We are a member or by which We are governed), information We hold about the claimant and the claimant's claims history.

We may need to collect sensitive data relating to the claimant (such as medical or health record or condition, etc.) in order to administer claims which arise. By your signature, you signify your consent to such information being disclosed by Us, our agents and other insurers for the purposes of insurance administration (including underwriting, processing, claims handling, reinsurance and fraud prevention).

I/WE HEREBY CERTIFY that to the best of my/our knowledge and belief the statements and particulars contained herein are fully made and that I/we have withheld no material fact concerning the accident or the injured person.

Signature of Policyholder ✗ ______________________ Date ✗ __ __ / __ __ / __ __ __ __

Important

The Policyholder is reminded that the Company cannot accept responsibility for payments made to injured persons without its authority. The Policyholder's attention is specially drawn to the fact that his interests and those of the Company are identical in as much as the future premiums payable depend upon the amount of compensation paid by the Company. The Policyholder should therefore do everything possible to prevent any but bone fide claims being admitted.

Please return completed form to:
Allianz p.l.c., Allianz House, Elmpark, Merrion Road, Dublin 4.
Telephone: (01) 613 3000 Fax: (01) 613 4444 Email: info@allianz.ie Website: www.allianz.ie
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