



Claims
 Primary General Insurance Limited
 PO Box 4220
 M60 3DH
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Employers Liability Claim Form

YOUR DETAILS

Policyholders Name(s)	
Policy No.	
Address	
	Postcode
Trade or Business	
Telephone (Inc. STD)	
Person to Contact	

DETAILS OF EMPLOYEE(S)

Name		Age	
Address			
	Postcode		
Telephone (Inc STD)			
Occupation / Department		Start Date	
Nat Ins No.		Clock/Work No	
Is the employee either a direct employee or a labour only sub-contractor? If 'Yes' please provide details	Yes / No		
Was the employee actually in the course of their employment? If 'No' please give details	Yes / No		
Is the employee married, widowed, single or have a partner?			
Number of dependent children?			
Did the employee have any physical defect or relevant medical history before the accident? If 'Yes' please give details	Yes / No		

INCIDENT DETAILS

Date & Time of incident		am/pm	
Where did incident occur?			
What was the nature of the work being performed?			
State length of experience in carrying out this type of work.			
Was the accident connected to machinery?	Yes / No		
Was the machinery guarded?	Yes / No		
Give details of any breach of Instructions			

NO ALTERATION SHOULD BE MADE TO SUCH MACHINERY WITHOUT OUR CONSENT

Has the accident been entered in your record book or on form F2509 in accordance with the Notification of Accident?	Yes / No
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If 'yes' please attach a copy of the entry together with forms F2058 (Notifiable Diseases) and BI 76 as soon as available

Has HM Factory Inspector/Health & Safety Executive/Local Authority investigated since the incident?	Yes / No
Has there been a warning of prosecution?	Yes / No
Has there been any breach of the Factories Act, the health and safety at work act or any other regulations? If 'Yes' please give details. Indicate the Name and Position of person in authority over the injured employee	Yes / No

