report of AWB claim

Underwriters Limited

This form should be completed as fully as possible and returned immediately to your Broker.

Please do not leave any blank spaces, although N/A may be inserted where appropriate.

1. EMPLOYERS DETAILS

Name of Employer:-

Policy No:-

Address:-

Claim No:-

Tel No:-

In conjunction with what trade or business did you employ the person in question?:-

2. EMPLOYEE DETAILS

Name of Employee:-

Age:-

Occupation:-

Address:-

Was he/she a servant in your direct employ? YES/NO

3. THE ACCIDENT (if applicable)

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Date of Accident:- Time:- am/pm

Date the injured person ceased work:-

Date of return to work:-

Did the accident happen on your premises?:- YES/NO

If 'No', please provide details of the Location:-

Describe fully how the accident occurred.

What injuries did the Employee sustain?:-

4. SICKNESS (if applicable)

State Symptoms & cause of illness:-

Dates of Absence: From: To:

Has the Employee suffered from this before? YES/NO

5. EMPLOYMENT DETAILS

How long has the Employee worked for you?:-

Is the Employee full or part time?:-

Please state the number of contracted days per week and number of contracted hours per day the Employee works:

Grade of Worker?:- If not a 'Standard Worker'. Please attach the certificate to confirm Grade.

Can you recover Statutory Sick Pay YES/NO
if 'Yes' please state amount:-

Please send medical certificates for the period the Employee is absent from work.

I/We declare that the above statements are true and correct to the best of my/our knowledge and belief. I/We have not withheld from the insurer any information within my/our knowledge connected with this claim. I/We understand that you may seek information from other insurers to check the answers I/We have provided, and I/We authorise the giving of such information for such purposes.
I/We agree to provide the insurers with any further information or documentation as may be reasonably required. I/We understand that the insurer does not admit liability by the issue of this form.

Date:- / /

Signature(s) of Policyholder(s)

Please return the completed form, with the documentary evidence of the amount claimed to your insurance advisor.

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