KENNCO Underwriting is regulated by the Central Bank of Ireland.

Employers Liability Claim Form

Please complete this form fully and return it to: KennCo Underwriting Ltd. Suite 7, Grange Road Office Park, Grange Road, Rathfarnham, Dublin.16.

Insured: _____ Policy Number:_____

Address:_____

Address of establishment where incident took place if different from above_____

_____

Business or occupation _____ Telephone Number:_____

INJURED EMPLOYEE:

Name: _____ Date of Birth_____

Address:_____ Date Employee joined Firm_____

Occupation:_____ Marital Status:_____

Is the injured person: (please tick)

☐ Employed Full Time ☐ Employed Part Time ☐ Self Employed ☐ A Trainee ☐ A family Member ☐ Other

ACCIDENT PARTICUALRS:

Date of Accident:_____ Time: _____

Location of Accident:_____

Accident reported to:_____ Time: _____ Date:_____

State the date in which the injured person ceased work:_____

Nature of work being performed at time of accident:_____

Describe fully how the Accident occurred:_____

_____

_____

_____

_____

_____

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DETAILS OF INJURY

Indicate type of Injury (tick box) Indicate part of body injured (tick box)

	Bruising ,contusion		Suffocation, asphyxiation		Head (except eyes)		Hip,
	Concussion		Gassing		Eyes		Thigh
	Internal Injuries		Drowning		Neck		Knee
	Open Wound		Poisoning		Back, Spine		Lower leg
	Abrasion, Graze		Infection		Chest		Ankle
	Amputation		Burns, Scalds, Frostbite		Abdomen		Toes
	Open Fracture		Electrical Injury		Shoulder ,Arm, elbow		Other
	Dislocation		Injury not ascertained		Hand		
	Sprain, Torn Ligaments				Fingers (one or more)		

Was such work part of his/her ordinary duties? Yes ☐ No ☐

Was any person negligent in any way? If so, give details:_____

_____

_____

_____

Was the employee given full instructions/training: Yes ☐ No ☐

Was he/she carrying out instructions as directed? Yes ☐ No ☐

Name and Address of any witnesses, please indicate if they are your employees:

1._____

_____

2._____

_____

3._____

_____

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CONSEQUENCES OF THE ACCIDENT:

Has the employee ceased work?_____Time:_____

Has the employee returned to work, and if so, when?_____

If not yet returned please state date employee is expected to return:_____

Anticipated absence if not back (please tick) ☐ **4-7 days** ☐ **8-14 days** ☐ **More than 14 days**

If removed to hospital or otherwise medically examined please state name and address of doctor and /or hospital:

_____

_____

CLAIM PARTICULARS:

Has claim for compensation been made against your company? Yes ☐ No ☐

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

Has the injured employee received compensation previously from:

(A) YOU? Yes ☐ No ☐

If yes, please date and details of injury / reason for compensation:_____

_____

_____

_____

(B) Any other employer? Yes ☐ No ☐

(C) Any other party Yes ☐ No ☐

Has the injured employee been paid wages while out of work? Yes ☐ No ☐

If yes, please state full details of any payments made:_____

_____

_____

Has the injured employee received any social welfare payments while out of work? Yes ☐ No ☐

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IMPORTANT

Please note that any third party correspondence or solicitors letters should be forwarded to us immediately unanswered

WAGES PARTICULARS

Statement of weekly wages / salary for injured employee for past 6 months

Week Commencing:_____ To week ending:_____

Week	Gross Wage	Net Wage	Week	Gross	Net Wage
1.			14.		
2.			15.		
3.			16.		
4.			17.		
5.			18.		
6.			19.		
7.			20.		
8.			21.		
9.			22.		
10.			23.		
11.			24.		
12.			25.		
13.			26.		
C/F			TOTAL		

Please state if safety statement in writing has been prepared in compliance with the Safety Health and Welfare at Work Act 1989?

YES ☐ NO ☐

DECLARATION

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

Signature of Insured_____Date_____