



KENNCO Underwriting is regulated by the Central Bank of Ireland.

Public 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. On behalf of Great Lakes Reinsurance (UK) PLC.

POLICYHOLDER

Insured: _____ Policy Number: _____

Address: _____

Business or occupation _____ Telephone Number: _____

Are there any other insurances which might cover this loss? Yes No

If yes, please give the name of insurers and Policy Number: _____

ACCIDENT DETAILS:

Date of Accident: _____ Time of Accident: _____

Location of Accident: _____

Describe fully how the Accident occurred: _____

Was the Accident reported and to whom? _____

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

1. _____

2. _____

3. _____

Please state name and address of Third Party:

Name: _____

Address: _____



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COMPLETE THIS SECTION IN THE EVENT OF ANY INJURY TO THE THIRD PARTY

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	Other	Fingers (one or more)	

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

Has any claim been made either verbally or in writing by or on behalf of the third party against you / your company?

Yes No

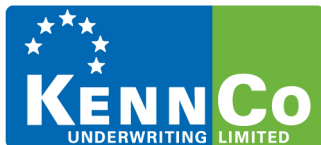
If yes, please give details _____

COMPLETE THIS SECTION IN THE EVENT OF DAMAGE TO PROPERTY

Describe the damaged property: _____

Where can the property be examined: _____

Approximate estimate of damage: _____



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COMPLETE THIS SECTION IN THE EVENT OF A PRODUCTS LIABILITY CLAIM

When was the product supplied? _____

Please state the name and address of suppliers/manufacturers: _____

What is the nature of the injury/complaint? _____

Were there any other complaints made in respect of the same product? Yes No

If yes please give details: _____

Has the product been examined/analysed? Yes No

If yes, please give details of the result: _____

Was the Health Board notified? Yes No

If yes, please give details of their findings/recommendations: _____

IMPORTANT

PLEASE NOTE THAT ALL THIRD PARTY CORRESPONDENCE SHOULD BE PASSED TO US IMMEDIATELY UNANSWERED

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 _____