

# Employer's Liability Accident Report Form

Please complete this form fully and return it to Allianz as soon as possible. Please note that the issue of this form is not an admission of liability on the part of the Company and that all claims are subject to Policy terms and conditions.

## Important Information for Pre-Claim Notifications

We only require the injured party's personal information (name, address) to be provided where (1) a formal claim has been made or (2) where there is clear evidence that a claim will be made. Otherwise this accident report form should be completed as normal, however the injured party's name should be recorded by way of initials only and no details of the injured party's address should be provided.

Claim No.

## Employer

Name and Business Address of Employer

  
  


Email:

Policy Number:

Date of last premium payment:  /  /

Business or Occupation:

Telephone Number:

Office Mobile:

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

## Injured Party

Name and Address of Injured Party

  
  


Date of Birth:  /  /

Occupation:

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

(a) the relationship (a)

(b) whether he/she resides with you Yes  No

Was the injured party 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:  /  /   am/pm

Address where accident occurred:

When and to whom was the accident reported by the injured party?  
 /  /   am/pm

Details of Accident (continued)

Did the injured party cease work? Yes  No

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

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

Was the injured party engaged in work for you at the time of the accident? Yes  No

State fully the nature of work upon which the injured party 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

If YES, please state breach(es).
\_\_\_\_\_
\_\_\_\_\_

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 party taken to hospital? Yes  No

If YES, state name of the hospital
\_\_\_\_\_

Is the injured party at present receiving medical attention? Yes  No

If YES, give details.
\_\_\_\_\_
\_\_\_\_\_

Claim Details

Has a claim for compensation been made against you? Yes  No

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

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

Earnings

State the net weekly earnings of the injured party. \_\_\_\_\_

State the total net weekly earnings including bonuses, overtime, allowances etc. of the injured party 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).

Grid of 6 rows and 28 columns for listing names and addresses.

Data Protection Acts - collection and use of personal information

The information you provide to Us when you report an accident/make a claim will be collected and used by Us to process your claim. Allianz p.l.c. is the data controller in respect of all such information, and references to We and Us in this statement shall be construed accordingly.

USES. Information you supply may be used for the purposes of insurance administration (including processing, claims handling, reinsurance and fraud prevention) by Us, our agents, our reinsurers, and any intermediary acting for you. In assessing any claims made, We may undertake checks against publicly available information such as electoral roll, court judgements, bankruptcy or repossessions.

DISCLOSURE. 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 you and your claims history. This includes Insurance Link, the Irish Insurance Federation's anti-fraud claims matching database. We may in certain circumstances use private investigators to investigate a claim.

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

RETENTION. Under the Consumer Protection Code we are obliged to retain your records for 6 years from the date your claim is settled. In certain circumstances we will retain your information for longer periods if this is required under specific insurance legislation.

CONSENT. By providing Us with your information and by your signature you consent to all of your information being used, processed, disclosed and retained for the purposes of insurance administration (including processing, claims handling, reinsurance and fraud prevention).

CALL RECORDING. Calls may be recorded or monitored for regulatory, training and quality purposes.

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 party.

Signature of Policyholder X \_\_\_\_\_

Date X \_\_\_\_/\_\_\_\_/\_\_\_\_\_

Important

The Policyholder is reminded that the Company cannot accept responsibility for payments made to injured parties without its authority. The Policyholder's attention is specially drawn to the fact that his/her 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 bona fide claims being admitted.

Please return completed form to:

Allianz p.l.c., Allianz House, Elmpark, Merrion Road, Dublin 4. Telephone: 1890 77 99 99 Fax: (01) 613 4444 Email: info@allianz.ie Website: www.allianz.ie Allianz p.l.c. is regulated by the Central Bank of Ireland. Registered in Ireland, No. 143108

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