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**NOTICE OF ACCIDENT – PUBLIC LIABILITY INSURANCE**

**EACH OF THESE QUESTIONS MUST BE ANSWERED COMPLETELY**

(This form is NOT to be used for vehicle accidents)

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NOTE: This form should be completed and returned to us as soon as possible, whether or not a claim is being made.

**(DO NOT DISCLOSE THAT YOU ARE INSURED)**

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POLICY NO.: \_\_\_\_\_ CLAIM NO.: \_\_\_\_\_

Insured \_\_\_\_\_

Address \_\_\_\_\_

Occupation/Business \_\_\_\_\_

Telephone No. \_\_\_\_\_

E-mail Address \_\_\_\_\_

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1. State carefully:

Date of Accident \_\_\_\_\_ Time \_\_\_\_\_ a.m./p.m.  
mm/dd/yy

Place where accident occurred \_\_\_\_\_

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2. Give full details of how  
accident occurred

3. Give Names and Addresses of all Witnesses

(State if witness is an employee or an independent witness)

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4. At the time of the accident what work were you or your employees engaged to do?

Name and Address of person who caused or who was to blame for the accident

Name and Address of person's Employer if not you

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5. Were particulars taken by the Police?

If "Yes", give Name and Number of Officer and Address of Police Station

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6. Do you have any other Policies covering you for this accident?

If "Yes", give particulars

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**PARTICULARS OF POSSIBLE CLAIMANT**

7. Name \_\_\_\_\_  
Address \_\_\_\_\_  
State nature of injury or damage \_\_\_\_\_

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8. Have you received notice of a claim ? \_\_\_\_\_  
If "YES", from whom and in what form? \_\_\_\_\_  
Date notified \_\_\_\_\_  
If claim is in writing please forward with this form \_\_\_\_\_  
mm/dd/yy

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I/We the undersigned, do hereby declare that, to the best of my/our knowledge and belief, the foregoing particulars are true and correct.

Signature of Insured/Claimant \_\_\_\_\_  
If Company Please Affix Company Stamp

Date \_\_\_\_\_  
mm/dd/yy