

Childcare Insurance Public Liability Report Form

PLEASE COMPLETE ALL PAGES OF THIS FORM AND RETURN IMMEDIATELY TO THE ADDRESS SHOWN

INSURED

Name

Policy Number

Address (incl postcode)

Email

Telephone number

Fax number

(a) Are you registered with Customs and Excise as a Taxable Person for VAT? Yes No

(b) If the answer to (a) is YES, do you obtain full remission of input tax from Customs? Yes No

(c) If the answer to (b) is NO (i.e. you are "partially exempted") what percentage are you provisionally assessed as being able to recover? %

DETAILS OF INCIDENT

Date & Time

Location

Has Incident been entered in your accident record book? If yes, Please supply a copy Yes No

Has Health & Safety Executive/ Local Authority/OFSTED Investigated since the Incident? Yes No

Has there been any warning of prosecution? Yes No

Has there been any breach of the Health and Safety at Work Act or any other Regulations Yes No

If YES, Please specify

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PUBLIC LIABILITY

Nature of work being carried out at the time

If in or about a building, is building owned/occupied by you Yes No

If NO, by whom

Type of building

Was anyone to blame Yes No

If YES, please specify whom and why

INJURIES

Name of injured person

Address

Postcode

Age

Describe injury

DESCRIPTION OF OCCURRENCE Please describe occurrence
Please enclose a diagram if applicable

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WITNESSES Please give names and addresses of witnesses (please provide further witness statements and documents where necessary)

If you have received a formal claim from the third party please ensure a copy of the letter is attached.

Please have all documents relating to the incident available for insurers to investigate the claim.

Return Claim form to:

Pound Gates & Co Ltd, St Vincent House, 1 Cutler Street, Ipswich, Suffolk. IP1 1UQ
Tel: 01473 216406 Fax: 01473 346092

I HEREBY DECLARE that the above statements are true to the best of my knowledge and belief, that no other Insurance is in force, and that I undertake to render such assistance in my power as Underwriters may require

Signature	<input type="text"/>
Position	<input type="text"/>
Date	<input type="text"/>