

Personal Accident Report Form



Completing the claim form

It is always important to notify your Insurer of a claim as soon as possible after an accident has occurred. Please therefore complete this form and return it to us within thirty days of the incident. We will then forward all relevant information and documentation to your Insurer.

Contact our Claims department or your Account Executive on the following numbers if you require any assistance with completing this form.

PLEASE COMPLETE ALL RELEVANT SECTIONS USING BLOCK CAPITALS. Tick the boxes and sign and date the form

Contact Numbers

Claims Department

Andrea Compton	0116 2999016
Sue Hitchcock	0116 2999020

Partners/Account Executives

Peter Turner	0116 2999005
Perry Turner	0116 2999002
Lee Turner	0116 2999013
Kevin Lewis	0116 2999003
Peter Shaw	0116 2999009

Paul Chesters	0116 2999023
Jeff Cook	0116 2999004
Ketan Popat	0116 2999064
James Fogg	0116 2999015

Should I make a claim?

All incidents should be advised to the Company whether or not it is your intention to make a claim against your policy.

Complaints Procedure

We will endeavour to deal with all aspects of your insurance requirements in a professional manner. Should you not be satisfied with any aspect of our service, you should refer the matter initially to your account executive. If you remain unsatisfied, you may request that a review of your case be conducted by the partners of Turner & Co. Your complaint will be acknowledged in writing within five days and the investigation completed within fourteen days of your request and a written reply submitted to you. If you are a retail customer as defined by the Financial Services Authority and are still not satisfied you can take your complaint to the Financial Ombudsman Service. Details are available on request.

Turner and Company

34-36 Princess Road West, Leicester. LE1 6TQ Tel: 0116 2999000 Fax: 0116 2999001 www.turnerand.co.uk
Authorised and regulated by The Financial Services Authority

Personal Accident Report Form



For office use only Turner and Co Claim Reference _____
Insurance Company _____

POLICYHOLDER

Name/Insured _____
Policy number _____
Address _____
Postcode _____
Daytime telephone number _____ Contact _____
Fax number _____
E-mail address _____

PERSON INSURED (if different from Policyholder)

Name _____ Date of Birth _____
Address _____
Postcode _____
Daytime telephone number _____ Occupation _____

ACCIDENT/INJURY

Date _____ Time _____ am/pm
Location _____
State fully what happened (continue on a separate sheet if necessary) _____

What injuries have been sustained? _____

Has any similar occurrence previously taken place? (If YES give details) Yes No _____

What precautions against the accident/injury had previously been taken? _____

What plant or equipment, if any, was involved? (any relevant equipment must be kept for inspection) _____

Was it properly guarded? Yes No Was guard in use? Yes No

Has any Authority investigated since the event? (If YES give details) _____

Name & Addresses of all witnesses (if written statements obtained, please attach) _____

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GENERAL

Has the person insured any pre-existing disease or physical defect? (if YES give details) _____

How long has the person injured been disabled from engaging in or attending to his usual employment or occupation as a result of the injury/illness?

Totally from _____ To _____

Partially from _____ To _____

Current earnings prior to claim period _____ Weekly/Monthly

Is the Injured person employed or self employed

DECLARATION

Insurers share information with each other to prevent fraudulent claims and for underwriting purposes. The information you supplied on this form, together with the information you have supplied on the proposal form and other information relating to the claim, may be provided to other Insurers.

The submission of a bogus or exaggerated claim, either in whole or in part, or of any false documentation or statement in support of a claim, may invalidate the whole claim and lead to your policy being declared void.

I declare that the above statements are true and correct to the best of my knowledge and belief. I have not withheld any information within my knowledge connected with this claim. I agree to provide the Insurer with any further information or documentation as may be reasonably required. I understand that the Insurer does not admit liability by the issue of this form.

Signature of Policyholder _____ Date _____

Signature of Insured Person _____ Date _____

Turner and Company

Personal Accident Loss of Earnings Form



Employer _____
Employee _____
Policy Number _____
Accident Date _____
Date ceased work following accident _____
Date returned to work following recovery _____

EMPLOYEES WAGE DETAILS

Please give details of injured employees earnings for thirteen weeks prior to the accident

Week Ending	Gross Pay	Income Tax	NI Contributions	Supplements	Net Pay after tax & NI

Please give details of any payments made to the employee since the accident

Wages (net) £ _____
Statutory sick pay £ _____
Other Payments (give details) £ _____

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