



KENNCO Underwriting is regulated by the Central Bank of Ireland.

Employers 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.

Insured: _____ Policy Number: _____

Address: _____

Address of establishment where incident took place if different from above _____

Business or occupation _____ Telephone Number: _____

INJURED EMPLOYEE:

Name: _____ Date of Birth _____

Address: _____ Date Employee joined Firm _____

Occupation: _____ Marital Status: _____

Is the injured person: (please tick)

- Employed Full Time Employed Part Time Self Employed A Trainee A family Member Other

ACCIDENT PARTICULARS:

Date of Accident: _____ Time: _____

Location of Accident: _____

Accident reported to: _____ Time: _____ Date: _____

State the date in which the injured person ceased work: _____

Nature of work being performed at time of accident: _____

Describe fully how the Accident occurred: _____



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DETAILS OF INJURY

Indicate type of Injury (tick box)

Indicate part of body injured (tick box)

<input type="checkbox"/> Bruising ,contusion	<input type="checkbox"/> Suffocation, asphyxiation	<input type="checkbox"/> Head (except eyes)	<input type="checkbox"/> Hip,
<input type="checkbox"/> Concussion	<input type="checkbox"/> Gassing	<input type="checkbox"/> Eyes	<input type="checkbox"/> Thigh
<input type="checkbox"/> Internal Injuries	<input type="checkbox"/> Drowning	<input type="checkbox"/> Neck	<input type="checkbox"/> Knee
<input type="checkbox"/> Open Wound	<input type="checkbox"/> Poisoning	<input type="checkbox"/> Back, Spine	<input type="checkbox"/> Lower leg
<input type="checkbox"/> Abrasion, Graze	<input type="checkbox"/> Infection	<input type="checkbox"/> Chest	<input type="checkbox"/> Ankle
<input type="checkbox"/> Amputation	<input type="checkbox"/> Burns, Scalds, Frostbite	<input type="checkbox"/> Abdomen	<input type="checkbox"/> Toes
<input type="checkbox"/> Open Fracture	<input type="checkbox"/> Electrical Injury	<input type="checkbox"/> Shoulder ,Arm, elbow	<input type="checkbox"/> Other
<input type="checkbox"/> Dislocation	<input type="checkbox"/> Injury not ascertained	<input type="checkbox"/> Hand	
<input type="checkbox"/> Sprain, Torn Ligaments		<input type="checkbox"/> Fingers (one or more)	
<input type="checkbox"/>			

Was such work part of his/her ordinary duties?

Yes

No

Was any person negligent in any way? If so, give details: _____

Was the employee given full instructions/training:

Yes

No

Was he/she carrying out instructions as directed?

Yes

No

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

1. _____

2. _____

3. _____



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IMPORTANT

Please note that any third party correspondence or solicitors letters should be forwarded to us immediately unanswered

WAGES PARTICULARS

Statement of weekly wages / salary for injured employee for past 6 months

Week Commencing: _____ To week ending: _____

Week	Gross Wage	Net Wage	Week	Gross	Net Wage
1.			14.		
2.			15.		
3.			16.		
4.			17.		
5.			18.		
6.			19.		
7.			20.		
8.			21.		
9.			22.		
10.			23.		
11.			24.		
12.			25.		
13.			26.		
C/F			TOTAL		

Please state if safety statement in writing has been prepared in compliance with the Safety Health and Welfare at Work Act 1989?

YES

NO

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 _____