

# public/products liability report form

All questions to be answered



Section 1 Your Details	
Policyholders Name(s)	
Address	
Postcode	
Business/Occupation	
Telephone Day	Evening
Person to contact	
Policy number	

All questions to be answered



Section 2 General Questions	
Date and time of Occurrence	<input type="text"/> / <input type="text"/> / <input type="text"/> am/pm
Where did the incident occur?	
If accident was connected with machinery insert YES or NO in boxes (a) and (b) below	
(a) was it properly guarded?	<input type="checkbox"/> (b) was guard in use? <input type="checkbox"/>
Has HM Factory Inspector/Health & Safety Executive/ Local Authority investigated since the incident?	Insert YES or NO <input type="checkbox"/>
Has there been a warning of prosecution?	Insert YES or NO <input type="checkbox"/>

Only complete if you are reporting a Public Liability incident



Section 3 Public Liability	
Nature of work being carried out at the time	
If in or about a building is building owned/occupied by you? Insert YES or NO <input type="checkbox"/>	
If 'NO' by whom?	
Type of building? (e.g. shop, factory etc)	<input type="text"/>
Was anyone to blame? Insert YES or NO <input type="checkbox"/>	
If 'YES' who and how?	
Did injured person admit it was his own fault? Insert YES or NO <input type="checkbox"/>	
Did anyone admit it was his/her fault? Insert YES or NO <input type="checkbox"/>	
If 'YES' who? (State name, address and Tel No.)	
If this person is not in your employment state by whom employed (Address/Tel No.)	
Were you working as a Sub-contractor? Insert YES or NO <input type="checkbox"/>	
If 'YES' give name, address and Tel No. of Principal Contractor	
Did anyone witness the incident? Insert YES or NO <input type="checkbox"/>	
If 'YES' give names, address and Tel Nos. (use the back of the form if necessary)	
When was the incident reported to you or your representative? <input type="text"/>	
If it was not reported to you to whom was it reported?	
Name	
Address	
Postcode	

Do you have any other insurance which may cover this claim? *Insert YES or NO*

*If 'YES' please give details*

**Only complete if you are reporting a Products Liability incident** 

**Section 4 Products Liability**

Details of Product

Please state if you manufacture, distribute, supply or retail the product?

What caused the claim?

Which product has given rise to the potential liability?

Was the product defective? *Insert YES or NO*

*If 'YES' give details*

Are any other products affected? *Insert YES or NO*

*If 'YES' please advise recall procedure*

What remedial action is being taken

Was the product used in accordance with instructions? *Insert YES or NO*

*If 'NO' please explain*

From whom did you obtain the defective product?  
Name   
Address   
Postcode

If contract work executed explain nature of contract

Do you have written contracts with either supplier or customer? *Insert YES or NO*

*If 'YES' give details*

Only complete if injuries sustained



**Section 5 Injuries**

If more than one person please list on the back of the form

Name	
Address	
Postcode	
Business/Occupation	Age
Employer	
Telephone Day	Evening

Injuries sustained

[Empty box for injuries sustained]

Name of doctor/hospital by whom treatment given

[Empty box for doctor/hospital name]

Only complete if Property Damage has occurred



**Section 6 Property**

Name and address of Owner of Property

Name	
Address	
Postcode	
Business/Occupation	
Telephone Day	Evening

Description of Property

[Empty box for description of property]

Nature of Damage to Property

[Empty box for nature of damage]

Amount claimed

[Empty box for amount claimed]

Please complete in all circumstances



**Section 7 Description of occurrence**

Description of occurrence and sketch plan if applicable

[Large empty box for description of occurrence and sketch plan]

Continue on the back of the form if necessary

Please complete in all circumstances



**Section 8 Declaration**

I/We declare that the foregoing statement is a true account to the best of my/our knowledge and belief

Signature	Position	Date	/	/
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