



Head Office: 1 Gray Street, Port of Spain
NOTICE OF ACCIDENT – PUBLIC LIABILITY INSURANCE
Information furnished will be treated as strictly private and confidential.
(This form is NOT to be used for vehicle accidents)

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

EACH OF THESE QUESTIONS MUST BE ANSWERED COMPLETELY

(DO NOT DISCLOSE THAT YOU ARE INSURED)

1. Policy No _____
2. Claim No _____
3. Name of Insured _____
4. Address of Insured _____
5. Occupation/Business _____
6. Telephone Contact No: _____
7. Email Address: _____
8. Please state carefully:
 - (a) Date and time of accident _____ AM PM
 - (b) Place where accident occurred _____

9. Give full details of how the accident occurred:

10. Give names and addresses of all witnesses (state if you are an employee or independent)

Name	Address

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

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

Name _____ Address _____

13. Name and Address of person's Employer (if not you)

Name _____ Address _____

14. Were particulars taken by Police?

Yes No

If yes, please give:

- (a) Name of Officer _____
- (b) Badge number of Officer _____
- (c) Address of Police Station _____
- (d) Who made the report _____
- (e) Date and time report was made _____ AM PM



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

Yes No

If yes, give particulars _____

16. Particulars of Possible Claimant:

(a) Full name _____

(b) Address _____

(c) State nature of injury or damage _____

(d) Email address _____

(e) Telephone no _____

(f) Age _____

(g) Date of Birth _____

(h) Marital Status _____

(i) Occupation _____

17. Have you received Notice of a Claim?

Yes No

If yes, from who and in what form? _____

If claim is in writing, please forward with this form

I/We hereby declare that the above statements are, to the best of our/my knowledge and belief, true in every respect

Date _____

Insured's signature _____