FIRST NOTIFICATION
EMPLOYERS LIABILITY CLAIM

Please return this form to the claims department:
Email: firstnotifications@wrightway.ie

REPORTED BY: _____

CONTACT NO.: _____ **REFERENCE:** _____

INSURED: _____

CONTACT NO: _____ **EMAIL ADDRESS:** _____

ADDRESS: _____

_____

_____

_____

POLICY NO: _____ **DATE & TIME OF INCIDENT:** _____

LOCATION OF INCIDENT: _____

IS THIS A LATE NOTIFICATION? _____

IF SO, WHY? _____

WAS THE POLICY OPERATIVE AT TIME OF INCIDENT? _____

WHAT IS THE NATURE OF PROPERTY DAMAGE? _____

IS THE THIRD PARTY AN EMPLOYEE? _____

WAS EMPLOYEE TAKEN TO HOSPITAL? _____

DID EMPLOYEE ATTEND HOSPITAL LATER? _____

HOSPITAL NAME? _____

WHEN WAS EMPLOYEE RELEASED? _____

WHAT ARE THE INJURIES? _____

HAS THE POLICY HOLDER PAID FOR MEDICAL EXPENSES? _____

EMPLOYEE/THIRD PARTY NAME: _____

EMPLOYEE/THIRD PARTY ADDRESS: _____

_____

_____

_____

EMPLOYEE/THIRD PARTY AGE: _____

EMPLOYEE/THIRD PARTY JOB TITLE: _____

FULL TIME OR PART TIME: _____

WEEKLY WAGE: € _____

IS EMPLOYEE OFF WORK? _____

IF SO, HOW LONG IS EMPLOYEE OFF WORK? _____

WHEN IS EMPLOYEE EXPECTED BACK TO WORK? _____

HAS POLICY HOLDER BEEN PAYING EMPLOYEE WAGES? _____

HAS A LETTER OF CLAIM BEEN RECEIVED? YES ☐ NO ☐

HANDLER: **DATE :**