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LIABILITY CLAIM FORM

PLEASE ANSWER EVERY QUESTION & SIGN THE DATA PROTECTION ACT CONSENT & DECLARATION ON THE FINAL PAGE

Policy Number		Claim Number		Your reference	
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POLICYHOLDERS DETAILS

Name					
Address					
			Post code		
Telephone Number					
Occupation/Business					
VAT registered	Yes/No				

INCIDENT

Date & time	
Location	
Full description of the incident	
Name of injured person	
Address	
Occupation	
Employee or member of the public	
Nature and extent of injury	
Did the injured person attend hospital	

To whom was the incident reported	
Has the incident been reported to the Health & Safety Executive	

WITNESSES

Name	Address	Relationship to injured person	Occupation

DATA PROTECTION ACT CONSENT

By signing this Consent I/we consent the use of the information held about me/ us including personal data and sensitive personal data in connection with this claim and in connection with insurers' provision to me/ us of insurance cover under the policy relevant to this claim or otherwise.

I/ we consent to the processing and transfer by Insurers of personal data and of sensitive personal data about me/ us where this is necessary (for example criminal convictions).

I/ we consent to the provision of details to third parties involved in providing insurance cover. These third parties may include insurance carriers, third-party claims adjusters, fraud detection and prevention services, reinsurance companies and regulatory authorities. I/ we acknowledge that this information may be disclosed to agents and insurers.

I/ we confirm that where I/we provide sensitive personal information which relates to anyone other than me/ us, I/ we must obtain the explicit consent of the person to whom the information relates both to the disclosure of such information as set out above.

I /we understand that the information provided will be treated in confidence and, where relevant, in compliance with the Data Protection Act 1998. I/we understand that I /we may apply for a copy of my/our information (for which I/ we may be charged a small fee) and to have any inaccuracies corrected.

Signature		Name in block capitals	
Position in company		Date	

DECLARATION

I/We declare that the foregoing particulars are true to the best of my/our knowledge and belief, I/we authorise the Company to make such admissions on my/our behalf as it deems appropriate and I/we agree to render the Company all assistance in the investigation of the Claim. I/we further agree to provide such assistance as may be necessary in pursuing recovery of any outlay. I/we confirm that I/we have not withheld any material information within my/our knowledge that may affect the granting of indemnity under my/our policy.

Signature		Name in block capitals	
Position in company		Date	