

U M ASSOCIATION LIMITED

EMPLOYERS' LIABILITY CLAIM NOTIFICATION FORM

Please send completed form together with all relevant correspondence to: **U.M. Association Ltd.**

5 St Helen's Place

London EC3A 6AB

Telephone: 0207 847 8670 Fax : 0207 847 868 E-mail: Aidan.Harvey@umal.co.uk

- Please Note:**
- 1. This form is to be completed by the employer**
 - 2. Under no circumstances should liability be admitted**

Member's Name

Member's Claim Ref.

1. EMPLOYEE DETAILS

a) Name

b) Full Address

c) Occupation

d) Date of Birth

e) Date employee ceased work (if applicable)

2. ACCIDENT DETAILS

a) Exact Location

b) Date **Time** **am/pm**

c) Circumstances and description of injuries sustained

2. Accident Details Cont.

d) Was Medical attention

given and, if so,
in what form?

3. WITNESSES

a) Name

Occupation Employee: yes/no

Address

b) Name

Occupation Employee: yes/no

Address

N.B. When available, please attach the following documents

<u>Document</u>	<u>Enclosed?</u>	<u>Document</u>	<u>Enclosed?</u>
Accident Report Form	<input type="text"/>	Witness Statement (s)	<input type="text"/>
Letter from solicitor	<input type="text"/>	HSE Form F2508	<input type="text"/>
Formal notification of claim	<input type="text"/>	Safety officer's report	<input type="text"/>
Other	<input type="text"/>		

Signed Position:

Please print name

Date