

# 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**

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a) Name

Occupation  Employee: yes/no

Address

b) Name

Occupation  Employee: yes/no

Address

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**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 style="width: 100px; height: 25px;" type="text"/>	Witness Statement (s)	<input style="width: 100px; height: 25px;" type="text"/>
Letter from solicitor	<input style="width: 100px; height: 25px;" type="text"/>	HSE Form F2508	<input style="width: 100px; height: 25px;" type="text"/>
Formal notification of claim	<input style="width: 100px; height: 25px;" type="text"/>	Safety officer's report	<input style="width: 100px; height: 25px;" type="text"/>
Other	<input style="width: 100px; height: 25px;" type="text"/>		

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Signed ..... Position: .....

Please print name .....

Date .....