

Commercial Liability Claim Form

Section 1 – Policy holder’s Details

Claim number	
Name of policy holder	
Contact address	
Position / job title	

Policy number	
Certificate number	
Daytime telephone	
Evening telephone	
Email address	
VAT status	

Section 2 – Details of the Incident

Exact date of the incident giving rise to this claim	
Description of exactly how the loss/damage occurred, including the address (Please attach a sketch and/or photographs if relevant. Please carefully preserve any broken parts of machinery, plant, equipment, tool or any other relevant item involved in the incident)	

Section 3 – Details of Claimant and Witness

Name of claimant	
Address of claimant	
Daytime telephone	

Evening telephone	
Age (approximate)	
Employee?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If not, what is their relationship to you?	

Please note that the witness must be able to discuss the incident if required to do so.

Name of witness	
Address of witness	
Daytime telephone	

Evening telephone	
Email address	
Age (approximate)	
Relationship to claimant	
Did this person actually see the incident occur?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Section 4 – Nature of the Injuries

If the Claimant is an employee, please attach a copy of the relevant Accident Book entry.

Please provide as much information about the nature of the injuries sustained below	
Did the Claimant receive any first aid or other treatment?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If so, who by?	
What treatment was administered?	
Did the Claimant attend Hospital?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If so, was the Claimant detained in Hospital?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Section 5 – Liability

Do you feel that you are liable for the incident?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If not, who do you feel is liable? Please explain why	

Important All correspondence received should be forwarded immediately, unanswered (in order to supply insurance details to the claimant's representative.

Section 6 – Details of Claim Made

Has any claim been made by, or on behalf of the Third Party / Claimant?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If so, please give details and the date of the claim, by whom and whether written or verbal	
Has the Claimant instructed their own solicitor?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Section 6 – Declaration

I/we declare that the information given within this claim form is true to the best of my/our knowledge and belief. I/we authorise the Insurers and their solicitors to deal with this claim and admit liability on my/our behalf if appropriate.

Full name and signature of the claimant or their representative	Date
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Please return to Stride Insurance Group Commercial Claims Department, Birch House, Parklands Business Park, Forest Road, Denmead, Hampshire PO7 6XP. Alternatively you can fax it to us on 02392 248799 or scan and email to claimservice@stride-group.co.uk.

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