



call 0845 500 1201 now  
Public liability pro-forma questionnaire

Your contact details:

Name
Address
Post Code
Tel no

Personal details:

Nat Insurance no.
Marital status
Date of birth
Next of kin if under 16
Occupation
Gross earnings per week
Net earnings per week
Employer's name and address

Accident details:

Date & Time of Accident
Place of Accident
Injuries Received

Date returned to work	Approximate wage loss
Previous accidents and injuries	Other losses and expenses
Name and Address of GP	SSP Received Welfare benefits received
Hospital where treated (& hospital records no)	Local DSS Office



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accident details continued:

Names and addresses of witnesses (if any)

Description of how the accident occurred and sketch if necessary

What happened after accident, comments made / admissions made

Any changes arising since the accident?

save

email to AJR

If you have any queries about filling in this form please call 0121 323 4443 or 07796 81 82 51