INJURY INVESTIGATION REPORT

INSURED DETAILS

Insured			
Policy Number			
Address		Post Code	
Name of Person Completing Form			
Role/Position			
Contact Telephone Number			

DETAILS OF INJURED PERSON

Who was the Injured Person?	
	Please Tick
An Employee	
A Labour Only Sub Contractor	
A Bona Fide Sub Contractor	
A Visitor / Member of Public	
Other (Please specify below)	

SPECIFICS OF INJURED PERSON

Full Name			
Address		Post Code	
Contact Number		Occupation	
If (a) an Employee or (b) a Labour Only Sub Contractor please also provide the following information:			
Date of Birth		NI Number	
Date Commenced Employment		Weekly/monthly Salary:	

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DETAILS OF THE ACCIDENT

Date of Accident	
Time of Accident	
Date Reported	
Person Reported To	
Accident Location	
Reported by	
Date Reported	
Accident Location	
Description of Accident	
If you believe that the Injured Person is either wholly or partly responsible for the accident then please provide full details below. Please also provide copies of any documentation which supports your position.	

	Please Tick	
	YES	**NO**
Was the accident recorded in the Accident Report Book?		
Was the accident reported to the Health and Safety Executive ("HSE")?		
Did you undertake a full Risk Assessment for the task being undertaken?		
If 'Yes' attached a copy. If 'No' attached a Post-Loss Risk Assessment.		
Were there any witnesses to the accident?		
If 'Yes' please provide details below and continue on separate sheet if necessary		

Name	**Address**
Please provide copies of any statements taken and/or complete the Witness Statement Form.	

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If (a) an Employee or (b) a Labour Only Sub Contractor please also provide the following information:		
	Please Tick	
	YES	NO
Did the accident involve a manual handling operation?		
If 'Yes' please provide details:		
Was the injured person wearing appropriate protective equipment?		
Please provide details:		
Was suitable training provided to the insured person for the task being undertaken at the time?		
If 'Yes' attach a copy of Training Records		

DETAILS OF INJURY

Please Provide Details of the Injury

	Please Tick	
	YES	NO
Was First Aid administered		
Was the Injured Person taken to hospital		
Has the Injured Person been off work as a result of the accident?		
If 'Yes' please provide details (dates of absence, date of return etc):		
Has the injured person returned to work in their normal capacity?		
If 'No' please provide details on how their working capacity has changed:		

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VISUAL EVIDENCE OF ACCIDENT

	Please Tick	
	YES	NO
Were any photograph taken at the time of the accident?		
If 'Yes' please attach copies		
Is there any CCTV footage of the accident?		
If 'Yes' please include copy of the footage		

DECLARATION

I/we declare that the above statements, supporting documents and/or media provided are true and correct to the best of my/our knowledge and belief. I/we have not withheld from the insurer any information within my/our knowledge connected with this claim. I/we agree to provide the insurers with any further information or documentation as may be reasonably required.

I/we confirm that lawful consent has been obtained from the injured party for the processing of their health and medical information and for the sharing of such information with Corin and the insurer.

I/we understand that insurers do not admit liability by the issue of this form.

Policyholders Signature		**Position**		**Date**	

PLEASE COMPLETE AND RETURN TO:	**claims@corin.com**
or by post to:	Corin Underwriting Ltd 148 Leadenhall Street London EC3V 4QT

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