O'LEARY
INSURANCE GROUP
WWW.OLEARYINSURANCES.IE

EMPLOYER LIABILITY ACCIDENT FORM

This form must be completed by the **Policy Holder** and **not** by the injured employee. No inspection of any plant, premises, of machinery other than the government officials should be permitted without the consent of the Insurer. Any evidence, or equipment which may be useful in asserting liability, should be carefully preserved, Any Third Party correspondence received should be forwarded to us immediately.

Please Complete, Sign and return to your O'Leary contact as soon as possible

1. EMPLOYER

Name of Employer: _____ Insurer + Policy Number: _____

Address: _____ Date of Payment of Last Premium: ___ /___ / ___ (DD/MM/20YY)

_____ VATRegistered: Yes ☐ No ☐

Business: _____ Telephone Number: _____

2. INJURED PERSON

Name of Injured Person: _____ Married ☐ Single ☐ Age _____

Address: _____ Occupation: _____

_____ RSI No: _____

State whether the injured person was in your direct employment or in the service of another employer? _____

_____

Was the injured person's employment casual ☐ or regular ☐

If casual, state how often employed and last period commenced? _____

If regular, how long has he/she been employed by you prior to the accident? _____

Did the employee undergo a Medical Examination on joining your firm? Yes ☐ No ☐ If so by whom? _____

Has the employee, to your knowledge, been involved in any previous accidents, in the course of his employment or outside his employment? If so please give detail _____

3. PARTICULARS OF ACCIDENT

State the date and time of accident: __ /__ / 20__ Time: ____ am ☐ pm ☐ State the name of place where accident occurred: _____

State the date on which the injured person ceased work: ___ /___ / ___ State the date on which the accident was reported Date: ___ /___ / ___

On what work was the employee engaged at the time of the accident? _____

Was the accident sustained: while the employee was working on machinery ? Yes ☐ No ☐ If so, specify the type of machine

Was the employee performing part of his/her duties at the time? Yes ☐ No ☐

As a result of the negligence of a fellow employee Yes ☐ No ☐ As a result of any defect in the premises? Yes ☐ No ☐

Detail: _____ Detail: _____

Was the injured employee guilty of any misconduct or disobedience of orders? If so give particulars:

Furnish names, occupations and addresses of witnesses of the accident: Furnish any further information in your possession bearing on accident::

_____ _____

_____ _____

4. INJURIES SUSTAINED

State fully the nature and extent of injuries: _____

Was the employee taken to hospital? Yes ☐ No ☐ Which Hospital: _____

If taken to hospital, as an in patient ☐ or as an out patient ☐ Discharge Date: ___ /___ / ___

If taken home, give the name and address of the doctor attending : _____

Is the employee being paid while absent from work? Yes ☐ No ☐ If so, how much and for how long will this payment continue?

State how many employees are in your service: _____ The amount of annual cash wages paid to them: _____

STATEMENT OF WAGES

Detailed Statement of weekly wages earned by_____ for six months previous to the date of his/her accident or for such less period as he / she may have been in his / her employers service.

N.B If the injured employee has been absent from work at any time during the period specified below, the reason for as well as the dates of such absence should be given.

	ENDING DATE	GROSS WEEKLY PAY	INCOME TAX DEDUCTED	WEEKLYPAY NET OF INCOME TAX AND PRSI
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				

	ENDING DATE	GROSS WEEKLY PAY	INCOME TAX DEDUCTED	WEEKLYPAY NET OF INCOME TAX AND PRSI
11				
12				
13				
14				
15				
16				
17				
18				
19				
20				

	ENDING DATE	GROSS WEEKLY PAY	INCOME TAX DEDUCTED	WEEKLYPAY NET OF INCOME TAX AND PRSI
21				
22				
23				
24				
25				
26				
7	Total Earned €			
8				
9				
10				

*Detail the exact circumstances in which the accident happened:

IMPORTANT: for your protection, please note that your policy provides that the employer shall not, without the consent in writing of the insurers, make any payment , settlement or arrangement in respect of any claim arising from injury to an employee, nor shall the employer without the like consent, make any admission of liability in respect of any such claim. I/We declare the forgoing particulars to be true in every respect.

Employers Signature: _____ Date: ___/___/___ See overleaf for particulars required.