



19, LIGALI AYORINDE STREET, VICTORIA ISLAND, LAGOS.

PROFESSIONAL INDEMNITY CLAIM FORM

NOTE: THIS FORM SHOULD BE COMPLETED AND RETURNED TO THE COMPANY AS SOON AS POSSIBLE
PLEASE ANSWER ALL QUESTIONS IN THIS FORM; TICKS AND DASHES ARE NOT SUFFICIENT.

PLEASE DO NOT ADMIT THAT YOU OR YOUR EMPLOYEES WERE AT FAULT, OR THAT YOU ARE LIABLE.

Policy Number.....
Name of the Insured
Address.....
Date of Payment of last premium.....
Business or Occupation..... Telephone number.....
Email Address:.....

1. Please give the following information about the accident.

- (a) When did it happen? At.....am/pm on.....
- (b) Where did it happen?
- (c) How did it happen? (Please give a rough sketch if possible).....

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2. Please give the following information about the work/job you/your employees were engaged to do

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3. Do you think that

- (a) you or any of your employees were to blame?
- (b) some other person was to blame?

4. Name and address of this employer if other than insured

5. Has any other accident ever occurred to any person or damage had been done under similar circumstances at the same place ?.....

If yes, give details

(Please turn overleaf)



6. Did the Police

- (a) witness the accident?.....
- (b) take any evidence or particulars.....

7. Please give the names and addresses of any witnesses;

- (i) Your own employees.....
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.....
- (ii) Others
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8. (a) Do you hold any other policies covering you for this accident?

If so, please give particulars
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PARTICULARS OF POSSIBLE CLAIMANT

9. (i) Name and address.....
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10. (a) Have you received notice of claim?

(b) If so, from whom, when and in what form?
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I/We declare that the foregoing answers are true and complete and that I/we hold no other policy indemnifying me/us in respect of this claim. I/We request you to deal on my/our behalf with the third party claims arising herein, in accordance with terms and conditions of the above mentioned policy, and I/we authorise you and your solicitors on my/ our behalf to make such admission and settlements and give such consents as you may consider necessary for the disposal of such claims and any litigation arising therefrom.

DATE.....

Insured's signature & stamp.....