LASACO ASSURANCE PLC

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RC. 31126

PUBLIC LIABILITY CLAIM FORM

Please answer all questions fully and return forms without delay.

Policy No | Claim No

Agency

Insured

Contact Address | State

Postal Address | State

Occupation

Telephone | Mobile | Email

Last premium Date:

Type of Business

Contact name

When and where did the accident happen? Date, hour and place. Please state as fully as possible.

What happened and what was the cause? Please state as fully as possible

By whose negligence, if any, was the accident caused? Name and address if possible

When was the accident first reported

Name and Address of your employees who were concerned in the accident

Name and address

Name of injuries

Occupations if known

Names of Employees if known

Was any property damaged? Yes ☐ No ☐
If 'yes' give particulars

Have you received any notice of a claim? Yes ☐ No ☐
If 'yes' give particulars

Names and addresses of witnesses

1

2

3

Number and division of police constable who took particulars

Any further information

NB. For your own protection, please note that your Policy provides that the Insured shall not, without the consent in writing of the Company, make any payment, settlement or arrangement in respect of any claim, nor shall be, without the like consent, make any admission of liability in respect of any such claim.

Signature of Insured _____ Date _____

Status of signatory
If a limited company

I/We the undersigned Policy holder hereby declare that the above statements and facts are true and that I/we have not withheld from the Company any information within my/our knowledge connected with the claim.

*Date*_____ *Signature of Policy Holder*_____
Please enclose medical certificate, if available.