



## Slip, Trip and Fall Accident Form

**Personal Details**

Full Name: \_\_\_\_\_

Address: \_\_\_\_\_

Tel. No. Home: \_\_\_\_\_ Work: \_\_\_\_\_ Mobile: \_\_\_\_\_

Occupation: \_\_\_\_\_ E-mail: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ National Insurance No: \_\_\_\_\_

Previously instructed Solicitor in respect of this case     No     Yes (If YES, please provide us with their details.)

Previously signed a No win-No Fee Agreement for this case     Yes     No

**Accident Details**

Date: \_\_\_\_\_ Place: \_\_\_\_\_ Time: \_\_\_\_\_

Did the Paramedics attend?     Yes     No

Name of the Paramedic: \_\_\_\_\_

Hospital Address: \_\_\_\_\_

**Conditions**

Where were you working?     Inside     Outside     Both

Where you working on a slope?     Yes     No     If NO, Specify \_\_\_\_\_

Inside     Dry     Wet     Other, Specify \_\_\_\_\_

Outside     Dry     Wet     Snowy/Icy     Other, Specify \_\_\_\_\_

Weather     Clear     Cloudy     Rain     Snow

Outside     Fog     Other, Specify \_\_\_\_\_

Light     Morning     Afternoon     Evening     Night

**Third Party Details**

Employee/Company Name: \_\_\_\_\_

Employee/Company Address: \_\_\_\_\_

Tel. No: \_\_\_\_\_

Insurance Company Name: \_\_\_\_\_

Insurance Company Address: \_\_\_\_\_

Policy/Reference No.: \_\_\_\_\_

Tel No: \_\_\_\_\_

**Loss of Earnings**

Will you have any loss of earnings?                       Yes                                       No

Do you keep records? (Do not send them)               Yes                                       No

Approximate Weekly net loss    £ \_\_\_\_\_                      Period off work \_\_\_\_\_

**Other Losses**

Loss of clothing/Other expenses (keep all receipts)                       Yes                       No

Loss 1: \_\_\_\_\_

Loss 2: \_\_\_\_\_

Loss 3: \_\_\_\_\_

Loss 4: \_\_\_\_\_

Loss 5: \_\_\_\_\_

Loss 6: \_\_\_\_\_

**Witness('s) Details**

**Witness 1**

Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
Home Tel. No: \_\_\_\_\_  
Mobile No: \_\_\_\_\_

**Witness 2**

Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
Home Tel. No: \_\_\_\_\_  
Mobile No: \_\_\_\_\_

**Witness 3**

Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
Home Tel. No: \_\_\_\_\_  
Mobile No: \_\_\_\_\_

**Witness 4**

Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
Home Tel. No: \_\_\_\_\_  
Mobile No: \_\_\_\_\_

**Witness 5**

Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
Home Tel. No: \_\_\_\_\_  
Mobile No: \_\_\_\_\_

**Witness 6**

Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
Home Tel. No: \_\_\_\_\_  
Mobile No: \_\_\_\_\_

**Witness 7**

Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
Home Tel. No: \_\_\_\_\_  
Mobile No: \_\_\_\_\_

**Witness 8**

Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
Home Tel. No: \_\_\_\_\_  
Mobile No: \_\_\_\_\_

**Description and Sketch of Accident**

Rough sketch/description of accident:

Brief description of accident: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Declaration**

I confirm that the above information I have given is correct to the best of my knowledge and request you act on my behalf in pursuing the claim for compensation arising out of the above incident, including issuing and signing Court Proceedings should this be required.

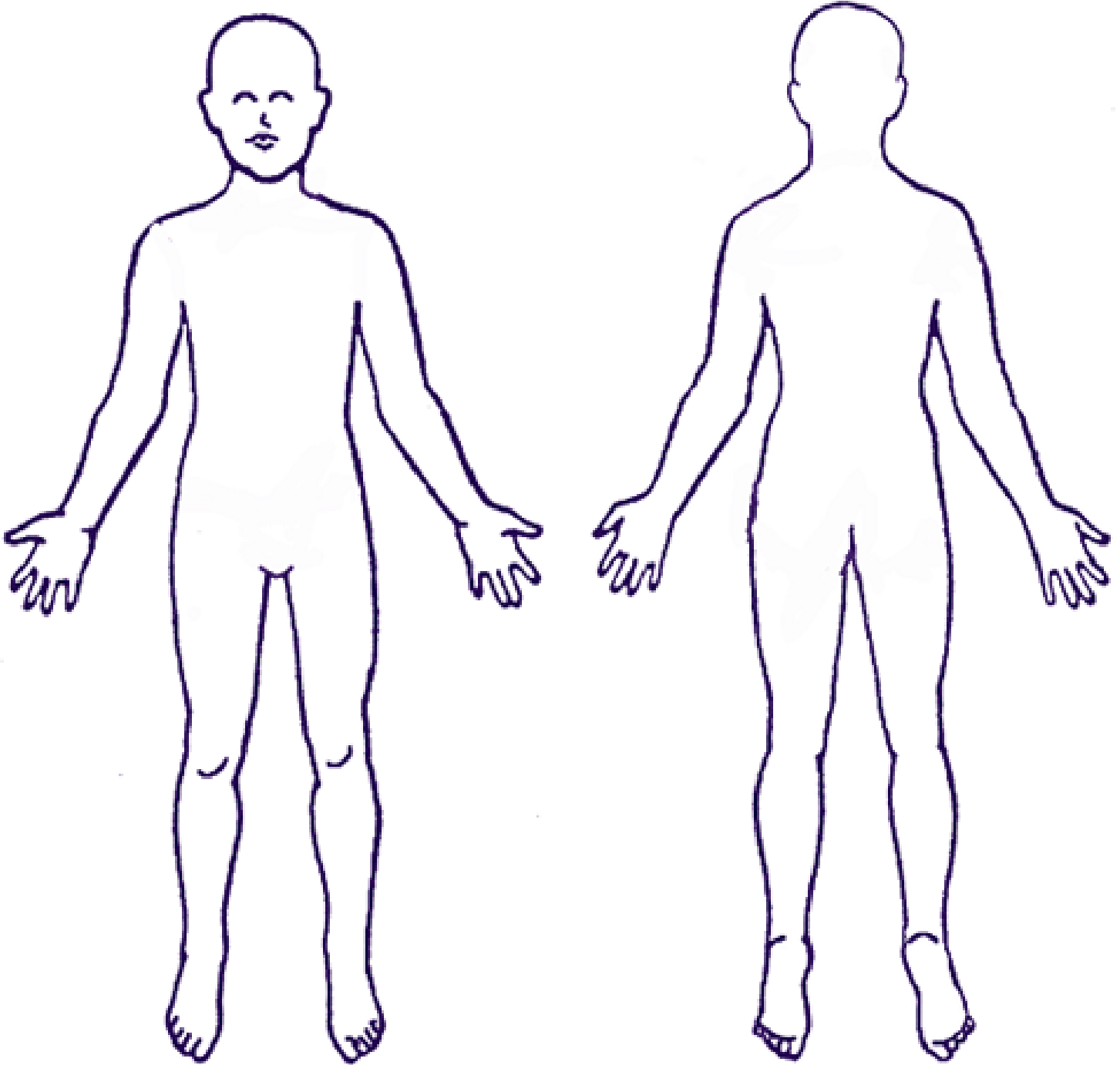


Signed:

Print Name: \_\_\_\_\_ Date: \_\_\_\_\_

**Body Injury Diagram**

In the diagram below can you please circle around the areas in which you were injured.



## Medical Checklist

**NOTE:** It is important that you complete this checklist accurately and truthfully and return it to us. Your claim may be adversely affected if you fail to disclose the information requested or in the event that you knowingly attempt to mislead us, the third party representatives or the Court, your claim will be compromised and you may be liable to costs consequences.

Client name: \_\_\_\_\_

Address: \_\_\_\_\_

Reference Number \_\_\_\_\_

Accident Date: \_\_\_\_\_

Have you been involved in any previous accidents?                       Yes                       No

If yes, please advise of the dates of each and every previous accident and confirm if you claimed personal injury as a result.

	Date		Yes	No
1	_____	Did you suffer any injuries?		
2	_____	Did you suffer any injuries?		
3	_____	Did you suffer any injuries?		
4	_____	Did you suffer any injuries?		

In the event that you claimed personal injury to an accident before which Solicitors represented you in respect of each claim? Please provide their full details even if it was we with reference numbers below:

	Accident Date	Solicitors	Telephone	References
1				
2				
3				
4				
5				

### STATEMENT OF TRUTH

I confirm the information provided in this checklist is correct and I do not have any further information to disclose which would have an affect on my personal injury claim.

I also confirm I have read and understood my report and confirm you may disclose this to the third party representatives.

Signed



Dated \_\_\_\_\_

**GP Consent Form**  
**(Releasing health records under the Data Protection Act 1998)**

**About this form**

In order to proceed with your claim, your solicitor may need to see your health records. Solicitors usually need to see all your records as they need to assess which parts are relevant to your case. (Past medical history is often relevant to a claim for compensation.) Also, if your claim goes ahead, the person you are making the claim against will ask for copies of important documents. Under court rules, they may see all your health records. So your solicitor needs to be familiar with all your records.

Your name: \_\_\_\_\_  
Your address: \_\_\_\_\_  
\_\_\_\_\_  
Date of birth: \_\_\_\_\_  
National Insurance Number: \_\_\_\_\_  
Solicitor's name: \_\_\_\_\_  
Solicitor's address: \_\_\_\_\_  
\_\_\_\_\_

GP's name: \_\_\_\_\_  
GP's address: \_\_\_\_\_  
\_\_\_\_\_  
GP's telephone no: \_\_\_\_\_

I consent to the disclosure of my General Practitioner's records, both past and present in line with the Data Protection Act 1998, to my Solicitors or to the specialist consultant nominated by my Solicitors, for the purpose of preparing a medico-legal report.

I would Confirm that no legal proceedings are contemplated against my GP or any his/her staff.



**Your signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

I have told my client the implications of giving me access to his or her health records. I confirm that I need the full records in the case.

**Solicitor's signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**AUTHORITY FOR RELEASE OF MEDICAL NOTES AND RECORDS PURSUANT TO THE ACCESS TO HEALTH RECORDS ACT 1990**

Your name: \_\_\_\_\_

Your address: \_\_\_\_\_

Date of birth: \_\_\_\_\_

National Insurance Number: \_\_\_\_\_

Solicitor's name: \_\_\_\_\_

Solicitor's address: \_\_\_\_\_

The hospital I have visited is:-

Hospital name: \_\_\_\_\_

Hospital address: \_\_\_\_\_

Hospital telephone No: \_\_\_\_\_

Name of Consultant in charge of treatment: \_\_\_\_\_

Departments where treatment was received: \_\_\_\_\_

Were any x-rays or scans taken?       Yes       No

Brief description of treatment	Dates	
	From:	To:

I consent to the disclosure of my hospital records and X-rays, to my Solicitors or to the specialist consultant nominated by my Solicitors, for the purpose of preparing a medico-legal report. This request is made pursuant to the Access to Health Records Act 1990 section 3 (1), (2) and (4) for which we volunteer an access fee of £10.00, together with reasonable copying and postage fee as prescribed by the Data Protection Act 1998.

I would confirm that no legal proceedings are contemplated against the Health Authority or any member of its staff.

Your signature: \_\_\_\_\_



Date: \_\_\_\_\_

Solicitor's signature: \_\_\_\_\_ Date: \_\_\_\_\_

**State Benefit Information Form**

- 1) The Law says that when you have been injured in an accident, any State Benefit which you have received as a result of such injury (e.g. SSP, Income Support, Invalidity benefit) must be deducted from any compensation payable to you by the compensating insurer.
  
- 2) For this reason, the insurer needs the following information BEFORE ANY MONEY CAN BE PAID to you, either by way of interim payment or final payment:

National Insurance Number: \_\_\_\_\_

Full Name: \_\_\_\_\_

Employer/Company Name (at time of accident): \_\_\_\_\_

Employer/Company Address: \_\_\_\_\_

Department/Section: \_\_\_\_\_

Position: \_\_\_\_\_

Works Ref: \_\_\_\_\_ Clock No. \_\_\_\_\_

**Proofs of Address and ID**

You must attach at least one document for each section and a document can not be used for both sections.

**Section 1**  
**PROOF OF ADDRESS**  
*(please attach 1 of the following)*

<b>Type</b>	<b>Company name</b>	<b>Account Number</b>
Electricity (No more than 3 months old)		
Gas (No more than 3 months old)		
Telephone (Land line only) (No more than 3 months old)		
Electricity (No more than 3 months old)		
Bank Statement (Not more than 3 months old)		
Council Tax Bill (Not more than 13 months old)		
Mortgage statement (Not more than 13 months old)		
Solicitor's letter conforming completion (Not more than 3 months old)		
DSS pension/ Allowance Book / Benefit Book		
Building Society Passbook (showing current address)		

<b>Type of ID</b>	<b>Issuing Country Name</b>	<b>Issuing Authority Name</b>	<b>Number</b>
Visa			

**Section 2**  
**PHOTOGRAPHIC ID**  
*(please insert 1 of the following)*

Type of ID	Company name	Number
Full Valid UK Driving License (old Style) (Not more than 51 years old)		
Full photo card License with supporting slip (not more than 10 years old)		
Provisional photo card License with supporting slip (not more than 10 years old)		
UK Passport		

Type of ID	Issuing Country Name	Issuing Authority Name	Number
Full Driving License (International and not more than 1 year old)			
Passport			
Visa			

I \_\_\_\_\_ (Clients Name) confirm that the documentation which I have provided is my own, it is authentic/original.



**Your signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

I, \_\_\_\_\_ (Rep name) hereby certify that I personally checked \_\_\_\_\_ (Clients Name) and **I confirm that 2 separate documents were checked against Identity and Proof of Address.**

**Rep signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

## Marketing Form

If you would kindly fill out this form we would be grateful.

Can you please indicate the form of advertisement which brought Hippo Claims to your attention.

- TV                      Please Specify \_\_\_\_\_  
\_\_\_\_\_
- Leaflets                Please Specify \_\_\_\_\_  
\_\_\_\_\_
- Billboards             Please Specify \_\_\_\_\_  
\_\_\_\_\_
- Magazines             Please Specify \_\_\_\_\_  
\_\_\_\_\_
- Exhibitions            Please Specify \_\_\_\_\_  
\_\_\_\_\_
- Sponsorship           Please Specify \_\_\_\_\_  
\_\_\_\_\_
- Vehicle Advertising   Please Specify \_\_\_\_\_  
\_\_\_\_\_
- Word of Mouth        Please Specify \_\_\_\_\_  
\_\_\_\_\_
- Shop Front            Please Specify \_\_\_\_\_  
\_\_\_\_\_
- Promotional Item     Please Specify \_\_\_\_\_  
\_\_\_\_\_
- Other                    Please Specify \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_