Industrial Disease/Deafness 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 Outside ○ Clear ○ Cloudy ○ Rain ○ Snow
○ 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

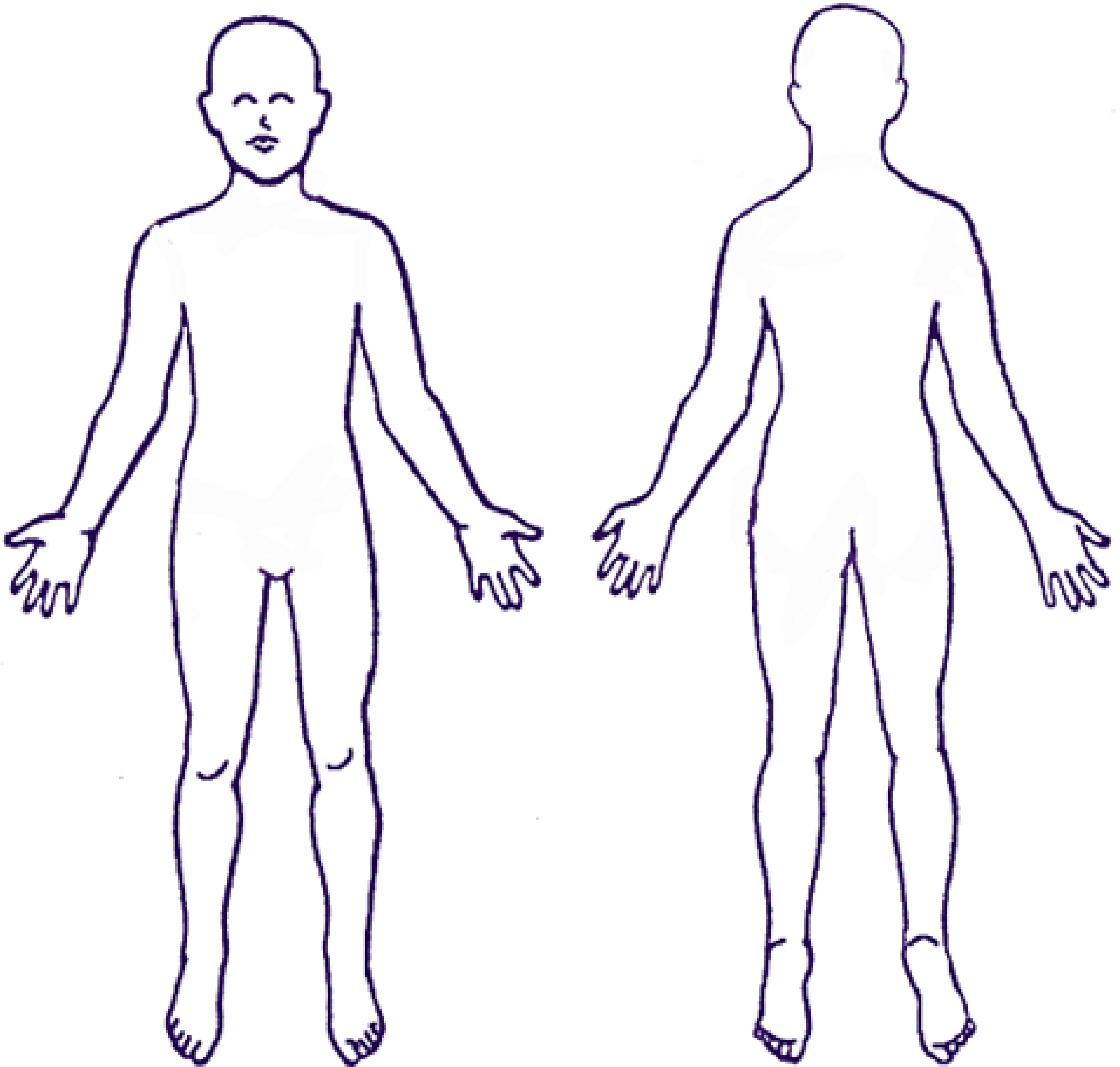
I confirm that the above information I have given is correct to the best of my knowledge and request you act on my behalf in pursuing the claim for compensation arising out of the above incident, including issuing and signing Court Proceedings should this be required.

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)

Type	Company name	Account Number
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)		

Type of ID	Issuing Country Name	Issuing Authority Name	Number
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 that 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 bought 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 ______________________