



Work 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.

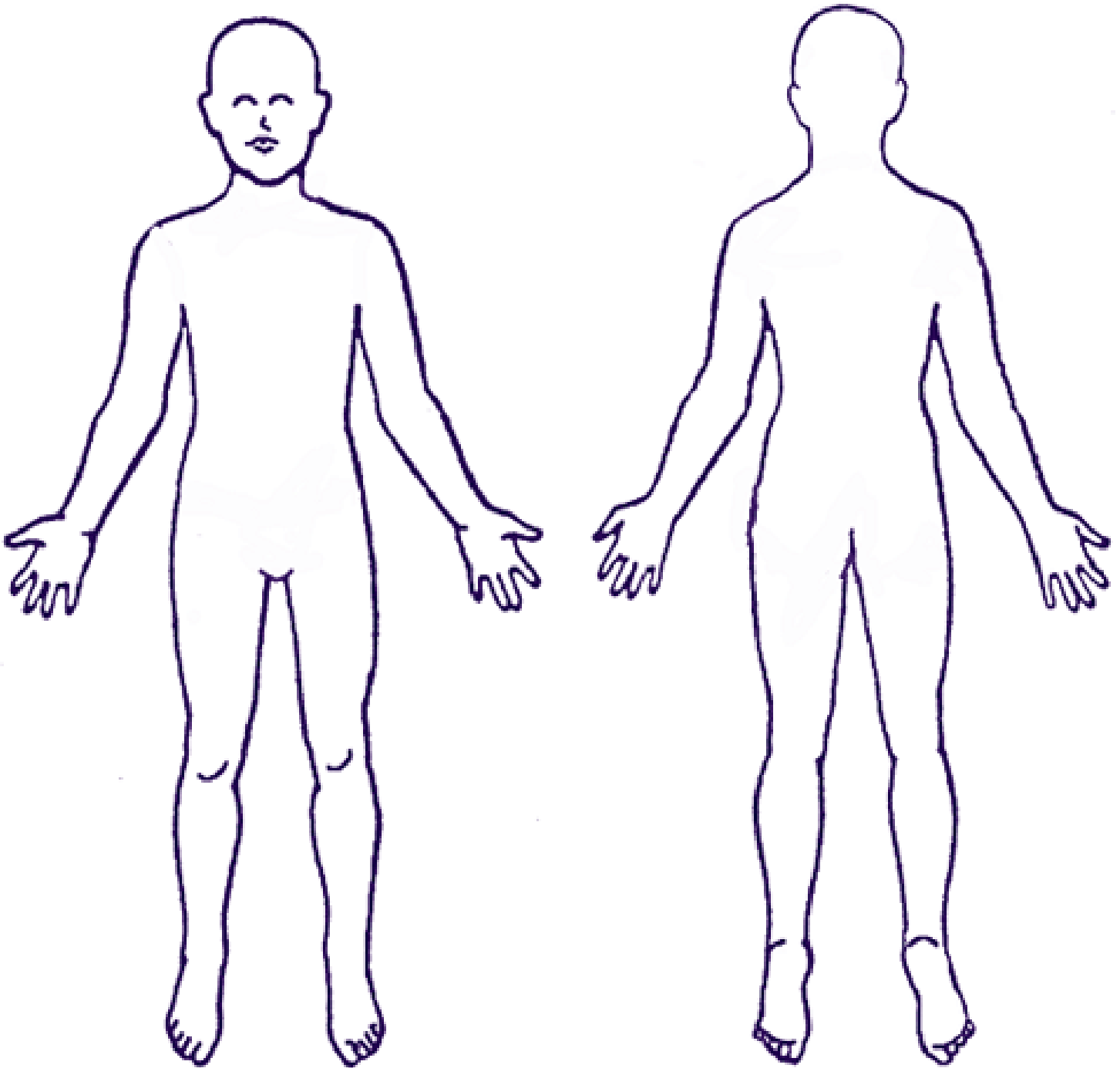


Signed:

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)*

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 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 _____

