Our Ref: **{** MERGEFIELD MATTER_FEE_EARNER_ID **}/{** MERGEFIELD client_no **}/{** MERGEFIELD matter_no **}**

Date: **{** SET LETTER**{** DATE \@ "d MMMM yyyy" **} }{**ref LETTER \@ "d MMMM yyyy" \ * MERGEFORMAT **}**

ACCIDENT QUESTIONNAIRE

You have losses and these will need to be claimed from the negligent party. When completing this form we only need answers for those sections which apply to you, but please complete the form fully and carefully since it is designed to give the information necessary to deal with your claim and information left off will lead to delays in settlement.

ACCIDENT QUESTIONNAIRE	**ANSWERS**
1. NAME	
2. ADDRESS	
3. TELEPHONE	
4. DATE OF BIRTH	
5. YOUR NATIONAL INSURANCE NUMBER	
6. MARITAL STATUS	
7. NAME OF NEXT OF KIN IF UNDER 18	
8. OCCUPATION	
9. GROSS EARNINGS pw	
10. NET EARNINGS pw	
11. EMPLOYER'S NAME	
12. EMPLOYER'S ADDRESS	
13. DATE AND TIME OF ACCIDENT	
14. **PLACE OF ACCIDENT** (TAKE PHOTOS OF DEFECT. IF POSSIBLE THE PHOTOS SHOULD SHOW THE SIZE OF THE DEFECT HAVING A RULER IN THE PHOTO WILL HELP) (IDENTIFY EXACTLY WHERE THE ACCIDENT OCCURRED, IF POSSIBLE BY REFERENCE TO A LANDMARK OR BUILDING)	
15. PRECISELY WHERE DID THE ACCIDENT OCCUR IN THE PREMISES (A SKETCH PLAN WOULD HELP)	

16. RETURNED TO WORK	
17. NAME & ADDRESS OF GENERAL PRACTITIONER	
18. HOSPITAL WHERE TREATED RECORD NO	
19. LOCAL DSS OFFICE	
20. NI NUMBER	
21. STATUTORY SICK PAY RECEIVED	
22. WELFARE BENEFITS RECEIVED	
23. **APPROXIMATE WAGE LOSS** HOW LONG OFF WORK?	
ARE YOU BACK AT WORK?	
DID YOU LOSE ANY EARNINGS AS A RESULT OF THE ACCIDENT?	
IF SO, HOW MUCH NETT?	
IF YOU HAVE RETURNED TO WORK, OR WHEN YOU DO RETURN TO WORK, PLEASE TELL US IF YOU HAVE NOT RETURNED TO YOUR NORMAL DUTIES AND OVERTIME.	
IF NOT YET BACK AT WORK, PLEASE ADVISE US OF THE DATE YOU RETURN	

24. **OTHER LOSSES AND EXPENSES**

PLEASE GIVE FULL DETAILS OF ALL LOSSES SET OUT BELOW ARE SOME EXAMPLES OF VALID ITEMS TO CLAIM

PRESCRIPTION CHARGES
FAMILY AND YOUR OWN TRAVELLING EXPENSES

25. PREVIOUS ACCIDENTS & INJURIES	
26. NAMES AND ADDRESS OF WITNESSES	
27. NAME AND ADDRESS OF PERSON OR BODY RESPONSIBLE. (WAS IT THE OWNER OR A CONTRACTOR)	
28. WAS ACCIDENT REPORTED TO THE OWNER (IF SO PLEASE PROVIDE THE REF. AND DATE)	
29. WAS THE DEFECT REPORTED TO THE OWNER BEFORE YOUR ACCIDENT (IF SO PLEASE PROVIDE THE REF. AND DATE AND THE NAME\ADDRESS OF PERSON MAKING THE REPORT)	
30. HAS THE DEFECT BEEN REPAIRED (IF SO PLEASE IDENTIFY THE REPAIRER AND DATE OF REPAIR)	

31.	WHAT TYPE OF SHOES WERE YOU WEARING	
32.	DO YOU WALK WITH THE AID OF A STICK OR ARE YOU DISABLED IN ANY WAY WHICH AFFECTS YOUR ABILITY TO WALK	
33.	DESCRIPTION OF HOW ACCIDENT OCCURRED AND SKETCH PLAN SHOWING POSITION OF DEFECTS, LIGHTS, WITNESSES ETC.	
34.	WHO HAD CONTROL OF THE PREMISES	
35.	WHY WERE YOU ON THE PREMISES	
36.	WERE YOU RUNNING OR WALKING	
37.	WAS ANY WARNING OR NOTICE DISPLAYED ABOUT THE DEFECT THAT CAUSED YOUR INJURY	
38.	INJURIES RECEIVED	
39.	ARE YOU IN A POSITION TO RECLAIM VAT?	

I **{** MERGEFIELD "LINKNAME_FORENAME_1" **} {** MERGEFIELD "LINKNAME_SURNAME_1" **}** of **{** MERGEFIELD "CLIENT_HOUSE" **}**, **{** IF **{** MERGEFIELD CLIENT_AREA **}**= "" "" "**{** MERGEFIELD CLIENT_AREA **}**, " **}{** MERGEFIELD "CLIENT_POSTAL_TOWN" **}**, **{** IF **{** MERGEFIELD CLIENT_COUNTY **}**= "" "" "**{** MERGEFIELD CLIENT_COUNTY **}**, " **}{** MERGEFIELD "CLIENT_POSTCODE" **}** hereby confirm that the information given in the Accident Questionnaire is true.

Signed .....

Dated.....

INJURY QUESTIONNAIRE

Please read these notes and complete questions.

When an accident occurs you invariably suffer from reaction to the accident, whether it be of a serious nature e.g. broken limbs, cuts, bruises etc. (for which more detailed evidence by way of medical reports will be obtained in due course), OR of a less serious nature e.g. shock, shaking up, trembling, loss of sleep, anxiety, apprehension etc.

In ALL cases where you have been affected by an accident in these ways it is proper that a claim for damages should be pursued against the Insurance Company. Will you please complete the form below relating only to your injuries, to provide us with information regarding the effects the accident had upon you in order that we may consider whether a claim for compensation on your behalf is appropriate.

PLEASE TICK BELOW (where appropriate)

TREMBLING

BROKEN LIMBS

LOSS OF SLEEP

CUTS

ANXIETY

BRUISING

APPREHENSION

SHOCK

OTHER (set out below)

SHAKING UP

PLEASE STATE MORE FULLY THE EFFECTS OF THE ACCIDENT UPON YOU

HAVE THE EFFECTS NOW SUBSIDED AND IF SO HOW LONG DID THEY LAST?

I **{** MERGEFIELD "LINKNAME_FORENAME_1" **} {** MERGEFIELD "LINKNAME_SURNAME_1" **}** of **{** MERGEFIELD "CLIENT_HOUSE" **}**, **{** IF **{** MERGEFIELD CLIENT_AREA **}**= "" "" "**{** MERGEFIELD CLIENT_AREA **}**, " **}{** MERGEFIELD "CLIENT_POSTAL_TOWN" **}**, **{** IF **{** MERGEFIELD CLIENT_COUNTY **}**= "" "" "**{** MERGEFIELD CLIENT_COUNTY **}**, " **}{** MERGEFIELD "CLIENT_POSTCODE" **}** hereby confirm that the information given in the Accident Questionnaire is true.

Signed .....

Dated.....

MITIGATION OF LOSSES

It is your legal duty to keep your losses to a minimum. Therefore when you feel able to return to work you should do so obviously in this context you will need to speak to your medical advisers. The insurers will not pay for loss of wages for a period in which they feel you could reasonably have been working.

CHEQUES ACT 1992

On the 16th June 1992 the Cheques Act 1992 became law. In consequence in order for us to complete your claim we would be obliged if you would kindly sign the attached authority.

File Ref:

Date of Accident: **{** MERGEFIELD TK_ACCDETS_tkACCDATE **}**

I **{** MERGEFIELD "LINKNAME_FORENAME_1" **} {** MERGEFIELD "LINKNAME_SURNAME_1" **}** of **{** MERGEFIELD "CLIENT_HOUSE" **}**, **{** IF **{** MERGEFIELD CLIENT_AREA **}**= "" "" "**{** MERGEFIELD CLIENT_AREA **}**, " **}{** MERGEFIELD "CLIENT_POSTAL_TOWN" **}**, **{** IF **{** MERGEFIELD CLIENT_COUNTY **}**= "" "" "**{** MERGEFIELD CLIENT_COUNTY **}**, " **}{** MERGEFIELD "CLIENT_POSTCODE" **}**
HEREBY REQUEST AND AUTHORISE the Insurance Company to draw a cheque in respect of my claim for damages arising out of the above mentioned accident in favour of my Solicitors, **{** MERGEFIELD "PRACTICEINFO_PRACTICE_NAME" **}**.

SIGNED.....

DATED.....