



PUBLIC LIABILITY ACCIDENT REPORT FORM

Policy No: Claim No:

- 1. Name of Insured:
- 2. Address of Insured:
- 3. Tel. No:
- 4. Business being conducted:
- 5. Date of Incident: Time of Incident:
- 6. Location:
- 7. When was the accident first reported to you and by whom?
- 8. Name of witnesses:
- 9. Name of injured third party/parties:
- 10. Address:
- 11. Age: (12) Sex: (13) Marital Status:
- 14. I.D. No: (15) National Ins. No:
- 16. Where is injured person at present?
- 17. Detailed description of incident or loss:
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- 18. Nature and extent of injury:
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- 19. If injury is to arm or hand, state which and whether left or right handed:
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- 20. Did he/she stop work immediately?

Trident Insurance Financial Centre
Highway 7, Hastings, Christ Church, BB15154 Barbados W.I.
Telephone: (246) 431-2347 Fax: (246) 427-5750
E-Mail: trident@tridentins.com www.tridentins.com

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21. If the accident arose from the action of a direct employee, please give name and address:

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22. If the accident arose from the action of a sub-contractor or his employee, please give details:

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23. Who was in charge at the time?

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24. If the accident was due to a defect in machinery, plant, or equipment, please state nature of defect.
(THE DEFECTIVE ITEM SHOULD BE RETAINED IN SAFE KEEPING)

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Premises

25. Was the accident due to any defect in the buildings or in the contents?

26. If due to any defect, who is legally responsible for the maintenance and repair?

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Insured's Signature

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Date

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