

LIABILITY INCIDENT REPORT FORM

Please complete in **BLOCK LETTERS** and answer **ALL** questions. This form should be immediately submitted to ICBL along with any relevant documents (including photos and video footage, where possible).

POLICYHOLDER

NAME:.....

CONTACT PERSON:.....

NUMBER/ EMAIL ADDRESS:.....

POLICY NUMBER & PERIOD:..... TO.....

OCCURRENCE

DATE OF INCIDENT:..... TIME:.....

LOCATION:.....

DATE REPORTED:..... REPORTED BY:.....

INCIDENT WAS REPORTED TO:.....

CLAIMANT

NAME:.....

MALE FEMALE AGE..... MARITAL STATUS.....

ADDRESS:.....

NUMBER/EMAIL ADDRESS:.....

EMPLOYEE OCCUPATION:.....

PATRON OTHER:.....

IF YES, please complete the below section. The statement should explicitly state what gave rise to the incident, along with the date, time and location of the occurrence as well as the injury sustained.

NAME:..... NUMBER:.....
ADDRESS:.....
RELATIONSHIP BETWEEN THE CLAIMANT AND THE WITNESS.....
IF THE WITNESS IS UNABLE TO COMPLETE THE BELOW SECTION, KINDLY SUBMIT A STATEMENT AS SOON AS POSSIBLE.

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DATE

.....
SIGNATURE

IF THE CLAIMANT IS AN EMPLOYEE, WAS HE/SHE PERFORMING A DUTY FOR WHICH FALLS UNDER THEIR JOB DESCRIPTION? YES NO

IF NO, PLEASE PROVIDE DETAILS:

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WAS THE CLAIMANT TREATED? YES NO PLEASE GIVE DETAILS:

MEDICAL FACILITY:.....

PHYSICIAN:.....DATE ATTENDED:.....

ANY OTHER INFORMATION:.....

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DID YOUR ORGANISATION INCUR THE CLAIMANT'S INITIAL MEDICAL COSTS WHEN THEY WERE TREATED? YES NO

KINDLY ADVISE WHAT CORRECTIVE MEASURE WAS PUT IN PLACE TO ENSURE THAT THIS TYPE OF INCIDENT IS NOT REPEATED:

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SUPERIOR'S NAME

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SIGNATURE

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DATE