Customer & Business Support Services

Insurance Section
West Offices
Station Rise
York
YO1 6GA

Tel: 01904 551550 or
01904 552953

QUESTIONNAIRE TO ASSIST IN THE CONSIDERATION OF A CLAIM FOR COMPENSATION

In order that your claim may be considered, please complete and return this form to the above address.

PLEASE COMPLETE IN BLOCK CAPITALS AND BLACK INK OR TYPESCRIPT.

The issue of this form by City of York Council is not to be taken as an admission of liability.

THE CLAIMANT

Name:

Date of Birth:

Address:

National Insurance Number:

Occupation:

Tel No (home):

Tel No (work):

Email Address:

Are you VAT registered? YES/NO

THE INCIDENT

Date:

Time:

Location:

State fully how the injury/loss occurred (additional space is provided on page 5):

Please give the names(s) and contact address(es) of any witnesses:

Was the incident reported to the Police? If so, please give details of the Police Officer and Station reported to, and the crime reference number:

DETAILS OF YOUR CLAIM

PLEASE COMPLETE THE APPROPRIATE SECTION(S) BELOW, (ADDITIONAL SPACE PROVIDED ON PAGE 5):

A. INJURY

If you have suffered any personal injuries please provide full details:

If you have attended a doctor or hospital for treatment, please provide the name of the doctor, the address and hospital number(if applicable):

B. LOSS OF EARNINGS

Period of absence (from and to):

Name and address of your employer:

Clock/employee number:

Hours of work: Full-time/Part-time

Did you claim DSS benefit for your period of absence? YES/NO

If yes, please provide the address of the DSS office:

C. MOTOR VEHICLE

If your vehicle was damaged please provide details of:

Vehicle Make: Vehicle Model:

Registration Number: Year of Manufacture:

Please state the nature of the damage, and provide the repair invoice or estimate if available. (if your claim relates to tyre or exhaust damage state approximately how many miles the tyre or exhaust had covered at the time of the incident):

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Location vehicle can be inspected, and who to contact, should this be necessary:

Name and address of the owner (if different from page 1):

The name of the person driving the vehicle at the time of the incident (if different from page 1):

The name and contact address of any passenger(s) in the vehicle at the time of the incident:

Details of any injuries sustained by any passenger(s):

If you have notified your motor insurance company about this incident, please provide the company's name, contact address and reference number:

What type of vehicle insurance do you hold for this vehicle? Comprehensive/Third-party

D. BUILDINGS

Address of the property damaged:

Type of property, e.g. house, flat:

Please state the nature of the damage, and provide the repair invoice or estimate if available (please include any damage to contents):

Date the damage was first observed:

If you have notified your buildings insurance company about this incident, please provide the company's name, contact address and reference number:

E. OTHER EXPENSES

Please provide details of any other loss you have suffered as a result of this incident, e.g. damaged clothing, prescription charges. Where appropriate please provide any invoices or estimates.

ITEM	ORIGINAL COST	AGE	REPLACEMENT COST

Please read the following declaration carefully before you sign and date this questionnaire

I declare that the information I have given is correct and complete to the best of my knowledge. I am aware that in order to protect public funds you may use the information that I have provided in relation to my claim to prevent and detect fraud. I understand that the information may also be shared with other departments and relevant external bodies for the same purpose.

Signed: .....

Date: .....

ADDITIONAL INFORMATION (Continued from Page 1)