



Highways Services

Selectapost 6
Ring Road
Middleton
Leeds LS10 4AX

Our Ref:

QUESTIONNAIRE TO ASSIST IN THE CONSIDERATION OF A CLAIM FOR COMPENSATION

In order that your claim may be considered, please complete and send this form to the address shown above. Please complete in block capitals. The issue of this form by Leeds City Council is not an admission of liability. **Failure to complete the relevant sections or to provide documents may result in consideration of your claim being delayed.**

FRAUD – Leeds City Council may use information given on this form and obtained from other sources, and also liaise with other authorities and agencies, to identify and prosecute individuals attempting to defraud the Council.

THE CLAIMANT

Name: _____ Date of Birth: _____
Address: _____ Occupation (if any): _____
Tel No (Private): _____ (Business): _____
Are you registered for VAT purposes?

THE INCIDENT

Date: _____ Time: _____ a.m./ p.m.

Place:

State fully how the injury/loss/damage occurred (additional space is provided on page 4).

Were there any witnesses to the incident? If so please give their name(s) and address(es):

If the incident was reported to the Police, please indicate where and when and the number of the Police Officer:

DETAILS OF CLAIM - PLEASE ANSWER EVERY QUESTION ON THE FORM IF YOU DO NOT ANSWER A QUESTION YOUR FORM WILL BE RETURNED TO YOU AND THIS WILL DELAY OUR INVESTIGATION INTO YOUR CLAIM

Section A - INJURY

Have you suffered any personal injuries Yes No (If yes please give full details)

If you attended a doctor or hospital for treatment please give the name and address and hospital number and sign the authority form on the back page.

Section B - EARNINGS

Have you suffered any loss of earnings Yes No (If yes please give the following details **and** sign the authority on page 3 - if you do not sign this then the authority can not investigate your claim)

Period of absence from: / / to: / /

Name and address of employer:

Clock/Works No:

National Insurance No:

Do you work part-time or full-time?

Were benefits claimed from Department for Works and Pensions for the period of sickness e.g. Incapacity Benefit?

Yes No

IF yes please give the address of the DWP office:

Section C – MOTOR VEHICLE

Was your vehicle damaged Yes No (If yes please give details):

Make:

Model:

Mileage:

Year of Manufacture:

Registration No:

How long have you owned the vehicle:

State the nature of the damage. If this includes damage to a tyre(s) or exhaust system, please state the approximate age and mileage covered by them at the time of the accident. If the items were new at the time of the damage, please attach documentary evidence in support of their purchase:

Please submit two repair estimates in respect of all damaged items (unless repair was required immediately, e.g. broken windscreen) and indicate when and where the vehicle may be inspected if necessary:

Please provide proof of vehicle ownership. If you are not the owner of the vehicle, please give the owner's name and address:

Who (if anybody) was driving the vehicle at the time of the accident?:

Please give the name and address of any passengers in your vehicle at the time:

Was anyone injured in the accident, if so, who:

Please provide a copy of the current MOT (if applicable) and Insurance Certificate. Please confirm whether or not you have reported the accident to the insurers. If so please give their name, address and reference number.

Please also advise details of insurance cover (i.e. Comprehensive or Third Party Fire and Theft)

Section D – BUILDINGS

Was your property damaged Yes No (If yes please give details)

Address of Property:

Type of Property (e.g. flat, house etc):

Nature of damage (Please also include details of any damage to the contents of the building):

When was the damaged first observed: Time: am/pm Date: / /

If you are not the owner of the property, please give the owner's name and address:

(If a repair estimate or invoice is available please attach a copy).

Have you told the insurers of the building about this matter? If so give their name, address and reference number:

Section E – OTHER EXPENSES

Have you suffered any other loss e.g. damaged clothing, prescription charges Yes No (If yes please give details. Please attach a copy of any estimates/invoices where appropriate)

ITEM(S)	ORIGINAL COST	AGE	REPLACEMENT
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EARNINGS AUTHORITY

I hereby authorise my employer to release to Leeds City Council details of my earnings prior to and subsequent to an accident on _____ in respect of which I have made a claim against Leeds City Council.

Signed

Date

MEDICAL REPORT AUTHORITY

I hereby authorise you to release to LEEDS CITY COUNCIL details of all injuries which I sustained and treatment given to me as a result of an accident on _____ in respect of which accident I have made a claim against the said LEEDS CITY COUNCIL.

In additional I authorise you to disclose my relevant previous general and medical history.

Signed Date

Full Name Date of Birth

Continued from Page 1

The information I have given on this form is true and complete. I am aware that the local authority can check the information that I have given in this form with information that I have provided to other departments within the Council for the prevention and detection of fraud (the authority is able to share information with other departments in accordance with Section 29(3) of the Data Protection Act 1998). I know that I am liable to prosecution if I have provided the authority with information that I know to be false.

NOW PLEASE SIGN AND DATE THIS FORM, TOGETHER WITH THE FORMS OF AUTHORITY ABOVE IF APPLICABLE.

Signed

Date