# Department for Work and Pensions Notification of a claim for compensation

Please use black ink and block capitals when completing this form

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| Notification of a claim for compensation made against an authorised insurer, as defined by the Road Traffic Accident (Compulsory Third Party Insurance) (Guernsey) Law,1936 (as amended by the Road Traffic (Compulsory Third Party Insurance (Amendment) (Guernsey) Law, 2012) (This involves the use of a motor vehicle on the road where the incident occurred on or after 1st November 2017).Details are to be provided in accordance with the Road Traffic (Compulsory Third-Party Insurance) (Recovery of Expenses) (Guernsey) Regulations 2017. |

## Injured person’s details

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| National Insurance (NI) number  | Date of birth |  |  |
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| Surname  | Date of death (if applicable) |  |  |
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| First forename(s) | Address  |
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| Other forename(s) |
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| Any other known surname(s) for examplemaiden name |
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| Title  | Sex(F for female, M for male) |
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## Reason for claim as alleged by the injured person

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| Motor Liability - [ ]   | Date of accident/incident |

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| Accident/incident – details of injury sustained resultingfrom the accident and condition/reason for whichcompensation is claimed (include specific body part injured, left or right where appropriate) |

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## Compensator details

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| Name of compensator or compensator’s representative |  | On behalf of: (enter name of compensator if representative’s details given opposite) |
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| Full postal address  |  | Your reference (maximum of 24 characters) |
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|  | Name of insured / policy holder or car registration |
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|  |  |
|  |  | Telephone |  | Fax |
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## Injured person’s representative details

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| Name of representative |  | Reference (maximum of 24 characters) |
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| Full postal address  |  | Telephone |
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## Hospital details

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| Did the injured person receive Guernsey HSC treatment because of the incident? | \*Yes[ ]  No[ ]  Not Yet Known[ ]   |
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| Details of the hospital(s) the injured person attended or admitted to in order of attendance. |
| Name of hospital 1 (if applicable) |  | Name of hospital 2 (if applicable) |
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| Address (if applicable) |  | Address (if applicable) |
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| Send this form to:What to do nowemail: | Debt Centre SunderlandCompensation Recovery UnitPost Handling Site BWolverhamptonWV99 2FRcru1@dwp.gov.uk |  |