



# A claim for compensation because of an accident or incident

## We have many different ways we can communicate with you

If you would like braille, British Sign Language, a hearing loop, translations, large print, audio or something else please tell us.

## Mandatory requirements

**Please answer all questions.** If this form is not completed correctly we may not be able to register the claim.

These are set out in:

- Regulations 3, 6 and 7 of the Social Security (Recovery of Benefits) Regulations 1997, and
- Regulation 7 of the Road Traffic (NHS Charges) Regulations 1999, and
- Regulation 5 of the Personal Injuries (NHS Charges) (General), and Road Traffic (NHS Charges) (Amendment) Regulations 2006.

Please use **BLOCK CAPITALS** if you are filling in this form with a pen.

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## About the injured person

1. National Insurance (NI) number
  
  
  
  
  
  
  
  
  
  
2. Surname
  
  
  
  
  
  
  
  
  
  
3. First forename
  
  
  
  
  
  
  
  
  
  
4. Other forename(s)
  
  
  
  
  
  
  
  
  
  
5. Any other known surname(s) for example maiden name

## About the injured person continued

6. Title

For example Mr, Mrs, Miss, Ms.

7. Gender

Female

Male

8. Date of birth - DD/MM/YYYY

/ /

9. Date of death (if applicable) - DD/MM/YYYY

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10. Address including postcode

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## Reason for claim

11. Please tell us the date of the accident or alleged clinical negligence.

DD/MM/YYYY

/ /

## About the accident or incident

12. If this compensation claim is because of an accident or condition, please describe the injuries that happened due to that accident. Include the specific body parts involved, for example left arm, left ankle.

**We cannot accept 'to be confirmed' or 'not known'.**

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## Name of disease

13. If compensation is also being claimed for condition(s) before the disease was diagnosed tell us in the box below.

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## Type of liability

14. Pick **one** option below:

employer

clinical negligence

public

motor

other - tell us here



## About the injured person's representative continued

24. Telephone number

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## About the hospital(s) attended because of the accident or incident

25. Did the injured person receive NHS treatment because of the incident?

No

Yes

Not yet known

26. Is the compensator the same as the Trust?

No

Yes      If **Yes**, do not complete hospital details.

**Please list the hospital(s) in the order the injured person attended.**

27. Name of first hospital (if applicable)

28. Address including postcode (if applicable)

29. Name of second hospital (if applicable)

30. Address including postcode (if applicable)

If further hospitals attended please provide details on a separate sheet.

## What to do now

Send this form to:  
Debt Centre Washington  
Compensation Recovery Unit  
Post Handling Site B  
Wolverhampton  
WV99 2FR

Or

Email: [cru1@dwp.gov.uk](mailto:cru1@dwp.gov.uk)

DD/MM/YYYY

**Date:**            /            /

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## Why DWP needs personal information and how we treat it

We will treat your personal information carefully. We may use it for any of our purposes. To learn about your information rights and how we use it, please see our Personal Information Charter at [www.gov.uk](http://www.gov.uk)