# 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 MOTOR TRAFFIC (THIRD PARTY INSURANCE) (JERSEY) LAW 1948. (This involves the use of a motor vechile on the road where the incident occurred on or after 26 February 2013).    Details are to be provided in accordance with the Motor Traffic (Third-Party Insurance) (Cost Recovery) (Jersey) Regulations 2013. |  |

## Injured person’s details

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| National Insurance (NI) number | | Date of birth |  |  | |
| |  | | --- | |  | |  | |  | | --- | |  | |  |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Surname | | Date of death (if applicable) |  |  | |
| |  | | --- | |  | |  | |  | | --- | |  | |  |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| First forename(s) | | | | | Address |
| |  | | --- | |  | | | | |  | |  |  | | --- | --- | |  | | |  | | |  | | |  | | | Postcode | |
|  | | | |  |
| Other forename(s) | | | | |
| |  | | --- | |  | | | | |  |
|  | | | | |
| Any other known surname(s) for examplemaiden name | | | | | |
| |  | | --- | |  | | | | |  | |
| Title | | Sex(F for female, M for male) | |
| |  | | --- | |  | |  | |  | | --- | |  | |  |

## Reason for claim as alleged by the injured person

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | Date of accident/incident | | |  | | --- | |  | |
|  | | | |
| Accident/incident – details of injury sustained resulting from the accident and condition/reason for which compensation is claimed (include specific body part injured, left or right where appropriate) | | |  | | --- | |  | |  | |  | | |
|  | | | |

## Compensator details

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

## Injured person’s representative details

|  |  |  |  |
| --- | --- | --- | --- |
| Name of representative |  | Reference (maximum of 24 characters) | |
|  |  |  | |
|  |  |  | |
| Full postal address |  | Telephone | |
| |  | | --- | |  | |  | |  | |  | | Postcode | |  |  |  |
|  |  | |
|  | Fax | |
|  |  |  |
|  |  | |

## Hospital details

|  |  |  |  |
| --- | --- | --- | --- |
| Did the injured person receive Jersey HCC treatment because of the incident? | | | \*Yes No Not Yet Known |
|  | | |  |
| 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) | |
|  |  |  | |

|  |  |  |
| --- | --- | --- |
| Address (if applicable) |  | Address (if applicable) |
| |  | | --- | |  | |  | |  | |  | | Postcode | |  | |  | | --- | |  | |  | |  | |  | | Postcode | |
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| --- | --- | --- |
| Send this form to: What to do now email: | Debt Centre Sunderland  Compensation Recovery Unit  Post Handling Site B  Wolverhampton  WV99 2FR  [cru1@dwp.gov.uk](mailto:cru1@dwp.gov.uk) |  |