OFFICIAL INJURY CLAIM

Re-allocation form

*The **Referring Insurer** is the insurer that was allocated the claim.*
*The **Responding Insurer** is the insurer that the referring insurer believes is the correct insurer to respond to the claim.*
*If you are a **Third Party Administrator** acting on behalf of an **Insurer** please complete section **1a** and/or **3a** where applicable.*
*All fully completed requests should be sent to OICreallocate@officialinjuryclaim.org.uk by the **Responding Insurer**. We require section 14 of the form to be completed by the **Responding Insurer** confirming whether the claim can be transferred or not.*
*Please note that OIC are unable to process requests that have been received from the **Referring Insurer**.*

1. Referring Insurer:	
1a: Third Party Administrator acting for Referring Insurer:	
2. Referring Insurer's internal reference:	
3. Responding Insurer:	
3a. Third Party Administrator acting for Responding Insurer:	
4. Responding Insurer's portal number:	
5. Date the SCNF was submitted	
6. Date re-allocation is requested	
7. Defendant's vehicle registration	
8. Make and model of the Defendant's vehicle	
9. Portal reference	
10. Any linked portal references:	
11. Date of accident:	
12. Defendant's details: a. Name of driver:	
b. Name of policy holder (if different from driver):	
c. Description of the defendant (if provided):	

13. Reasons why the Referring Insurer should not respond to the claim and re-allocated (including whether any other insurers might be involved):	• • • •

Please enclose any additional documents you hold which will assist the Responding Insurer with determining whether they should respond to this claim.

Name of person referring:	
Position:	
Organisation:	
Date:	

Tick as appropriate:

14. The Responding Insurer:	a. does consent to the re-allocation of this claim.	☐
	b. does not consent to the re-allocation of this claim.	☐
15. Responding Insurer's policy number:		
16. If the Responding Insurer is not consenting to the re-allocation of the claim please set out brief reasons for the refusal:	• • •	

Name of person confirming:	
Position:	
Organisation:	
Name and Office of Organisation the claim is to be transferred too if different from the above:	
Date:	