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.

*All fully completed requests should be sent to* [*OICreallocate@officialinjuryclaim.org.uk*](mailto: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: |  |
| 2. Referring Insurer’s internal reference: |  |
| 3. 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: |  |
| 1. Defendant’s details:    1. Name of driver:    2. Name of policy holder (if different from driver):    3. Description of the defendant (if provided): |  |
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|  |

|  |  |
| --- | --- |
| 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: | 1. does consent to the re-allocation of this claim. 2. 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:** |  |
| **Date:** |  |