



LIABILITY CLAIM REPORT

POLICY HOLDERS DETAILS

Policy Number (From your schedule)

Expiry Date

Insured (Surname, Company, Partnership, Occupation)

Given Name(s) of the Insured

Contact Person (for the company or partnership)

Are you registered for GST Purposes?

No

Yes

What is your ABN?

Have you claimed or do you intend to claim an input tax credit on the GST applicable to this policy?

No

Yes

Percentage Claimable

Address

Contact Number

INCIDENT DETAILS

Date

Time

AM

PM

Location of Incident

Purpose for which location was being used

Describe the Incident (including the cause and source of information)

PRODUCTS LIABILITY

Product Name

Model Number

Serial Number

Customers Name

Customers Phone Number

Customers Address

PROPERTY DAMAGED

Nature and extent of damage

Estimated cost

Name of Owner of damaged property

Address

Contact Number

Name of Person injured

Age

Sex: - Female

Male

Occupation

Address

Nature of Injury

Was treatment given at the scene of the incident?

Yes

No

If yes, by whom (if ambulance or doctor, give details)

Was transport provided to hospital?

Yes

No

WITNESSES

Were they any witnesses to the incident?

Yes

No

(If yes please complete the following)

Name

Address

Contact Number

Where was the witness?

DECLARATION

Declaration

I declare that to the best of my knowledge and belief the information in this form is true and correct and I have not withheld any relevant information.

Signature of Insured or person with authority to sign
For and on behalf of a company or partnership

Date