

LIABILITY CLAIM FORM

Claim Number:

1. Details of Policy Holder

<p>Name of Policy Holder: Address of Policy Holder: Postcode</p>	<p>Occupation or Trade: Telephone Numbers: Business Hour (.....) After Hour (.....)</p>	
<p>Insurer: </p>	<p>Policy No: </p>	<p>Expiry Date: / / 20.....</p>

2. Details of Accident / Injury

<p>Date of accident:</p>	<p>..... / / 20.....</p>	<p>Time of accident: am/pm</p>
<p>Was there any personal injury? <i>If yes, please state:</i></p>	<p><input type="checkbox"/> YES <input type="checkbox"/> NO</p>	
<p><i>(i) name(s) and address(es) of injured persons:</i></p>	<p>1. Name:</p> <p>Address:</p> <p style="text-align: right;">Postcode</p> <p>2. Name:</p> <p>Address:</p> <p style="text-align: right;">Postcode</p>	
<p><i>(ii) nature and extent of injuries:</i></p>	<p>1.</p> <p>.....</p> <p>.....</p> <p>2.</p> <p>.....</p> <p>.....</p>	

<i>(iii) name of doctor and/or hospital (if applicable)</i>	1. 2.
Was any third party property damaged? <i>If yes, please state:</i>	<input type="checkbox"/> YES <input type="checkbox"/> NO
<i>(i) name(s) and address(es) of owner(s):</i>	1. Name: Address: Postcode 2. Name: Address: Postcode
<i>(ii) nature and extent of damage:</i>	1. 2.
Is the third party:	(i) an employee of the policyholder? <input type="checkbox"/> YES <input type="checkbox"/> NO (ii) an employee of a sub-contractor? <input type="checkbox"/> YES <input type="checkbox"/> NO (iii) a member of the policyholder's family? <input type="checkbox"/> YES <input type="checkbox"/> NO (iv) ordinarily resident in the policyholder's home? <input type="checkbox"/> YES <input type="checkbox"/> NO
Has the claim been intimated:	(i) verbally? <input type="checkbox"/> YES <input type="checkbox"/> NO <i>(If yes, to whom)</i> (ii) in writing? <input type="checkbox"/> YES <input type="checkbox"/> NO <i>(If yes, please attach correspondence)</i>

3. ABN Details

Are you a registered business? <input type="checkbox"/> Yes <input type="checkbox"/> No
What is your ABN? ABN No:
What percentage of GST in your premium did you claim as an Input Tax Credit for the period of insurance in which this loss occurred?%

4. Declaration

I declare that the above statements are true, that I have not suppressed or mis-stated any facts. I expressly agree that the information given by me is provided with my full knowledge and consent and further agree to hold harmless and indemnify Direct Insurance Brokers in the event of any action or matter that may be taken by any party pursuant to the Privacy Act 1988 (Cth).	
Full name of claimant(s) <i>(please use block letters)</i>	
.....	
Signature(s)	
.....	Date: / / 20.....
.....	Date: / / 20.....