

COMBINED P.I. AND B.L. POLICY

NOTIFICATION OF AN OCCURRENCE OUT OF WHICH A CLAIM UNDER THE BROADFORM LIABILITY POLICY COULD ARISE

Please do not include any statement or comment on this form which could be construed as an admission of fault.

Please attach any supplementary information and relevant correspondence.

ı	Insured's details							
1.	Name(s) of the Insured							
2.	Insured's address							
	Postcode							
3.	Contact name Telephone no.							
4.	Email address							
5.	Policy number							
6.	Period of insurance from \Box \Box $/$ M M $/$ Y Y to \Box \Box $/$ M M $/$ Y Y							
7.	Are you registered for GST purposes? No Yes What is your ABN?							
8.	a. Are you entitled to an Input Tax Credit on 100% of the GST paid on your insurance premium? No Yes							
	b. Is your entitlement 100%? Yes No Please specify your percentage entitlement %							
(Claim details							
1.	When did the accident happen?							
	D / M M / Y Y Time a.m. p.m.							
2.	a. Address where accident happened							
	Postcode							
	b. Are you the owner and/or occupier of the land or buildings at the address?							
	No Yes Name of owner/occupier							
	Address							
-	Postcode							
3.	Describe what happened							

4.	a.	Was	the a	ccident ca	used by a defect or hazard on the property v	where the accident happened?				
		No		Yes	How long had you been aware of it?					
b. Had anyone notified you of the defect or hazard before the accident?										
		No		Yes	When were you notified?					
					DD/MM/YY					
					Who notified you?					
5.	W	ere tl	here a	ny witnes	es?					
	No)	Yes		Name of witness		Telephone			
				ŕ						
					Address					
				,				Postcode		
					Name of witness		Telephone	no.		
					Address					
								Postcode		
6.	D	id the	e polic	e attend t	ne accident?					
	No		Yes		Officer's Name					
					Name of station					
7.	Н	ave y	ou rec	eived a cl	im from the injured person, or the owner o	of the damaged property?				
	No)	Yes	; <i>/</i>	ttach any correspondence relating to this	claim.				
8.	W	hat r	elatio	nship exis	s between the the injured person, or the o	wner of the damaged property and	you (e.g. clie	nt, visitor, emլ	oloyee)?	
F	ro	pert	y det	ails						
		_			nd the damage.					
••		CJCIIK	, , , ,	property	ind the damage.					
_	4 t		-l							
۷.			ea cos	oi repair	or replacement.					
		\$								
I	njı	ıry d	etail	5						
1.	a.	Nan	ne and	d Address	f injured person					
		Nar	ne							
		Ad	dress							
								Postcode		

	b.	Occupation							
		Employer							
	c.	Age	Male	Female	Private telephone no.		Business telephone no.		
2.	Wł	nat were the inju	ries?						
3.	Wa	as medical assist	ance ne	ecessary?					
	No	Yes		Doctor	Ambulance	Hospital			
			Na	me of Doctor		·			
			Na	me of Hospital					
	Declaration								

I declare that I am the person completing and executing this form and am authorised by the insured/policyholder to do so and that to the best of my knowledge and belief the information supplied by me herein is true and correct and I have not withheld any relevant information.

I agree that, by submitting this form, the personal information I provide to Pacific Indemnity in this form or otherwise may be collected, held, used and disclosed in the manner set out in the Pacific Indemnity Privacy Policy found at http://www.pacificindemnity.com.au/privacy-policy, including for processing this claim.

Signature of the insured or person with authority to sign for and on behalf of a company or partnership

Date

D D / M M / Y Y

On completion of this form, please print and sign. When ready, please return the form to Pacific Indemnity Claims via mail or e-mail.

Pacific Indemnity Underwriting Solutions Pty Ltd PO Box 2 Collins Street West, Melbourne 8007 Email claims@pacificindemnity.com.au

> Insurer Insurance Australia Limited ABN 11 000 016 722 AFSL 227681

