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.

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 D D / M M / Y Y to D D / 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 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 accident caused by a defect or hazard on the property 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?

D D / M M / Y Y

Who notified you?

5. Were there any witnesses?

No ☐ Yes ☐ ▶ Name of witness

Telephone no.

▶ Address

Postcode

▶ Name of witness

Telephone no.

▶ Address

Postcode

6. Did the police attend the accident?

No ☐ Yes ☐ ▶ Officer's Name

Name of station

7. Have you received a claim from the injured person, or the owner of the damaged property?

No ☐ Yes ☐ ▶ Attach any correspondence relating to this claim.

8. What relationship exists between the the injured person, or the owner of the damaged property and you (e.g. client, visitor, employee)?

Property details

1. Describe the property and the damage.

2. Estimated cost of repair or replacement.

$

Injury details

1. a. Name and Address of injured person

Name

Address

Postcode

b. Occupation

Employer

c. Age Male Female Private telephone no. Business telephone no.

2. What were the injuries?

3. Was medical assistance necessary?

No Yes Doctor Ambulance Hospital

Name of Doctor

Name 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.

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