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LIABILITY CLAIM FORM

Important Notes

IMPORTANT: Please read the following

1. The Policyholder should not disclose to Claimants the existence of a policy.
2. Please do not reply to any communication from Claimant or it's legal representative but forward it to the company.
3. This form is issued without prejudice and it is not an admission of liability by the company.

Client Details

Are you registered for GST purposes? Yes No

What is your ABN? _____

Have you claimed, or intend to claim an input tax credit on the GST component of the premium applicable to this policy?

No Yes If yes, will you be claiming an amount less than 100%? No Yes

If yes, specify amount claimed? _____%

Are you entitled to claim an input tax credit for repairs or replacement of the item that has been lost or damaged?

No Yes If yes, will you be claiming and amount less than 100%? No Yes

If yes, specify amount claimed? _____%

Agent/Broker: _____

Due Date: _____

Policy Number: _____

Claim Number: _____

Name of Insured: _____

Address: _____

Contact Number: Private: _____ Business: _____

Email Address: _____

Occupation: _____

Claim Details

Date of the accident: ____/____/____

Time of the accident: ____/____/____

Location and place of the accident:

State fully and clearly the circumstances surrounding the accident:

Claim Details (continued)

In your opinion, was another person responsible for this event?

Yes No If yes, please give name, address and telephone number.

Name: _____

Address: _____

Telephone No.: _____

Relationship of injured person/property owner to the insured:

Is the property owner a relative, friend or contractor to the insured?

Yes No

Were there any witnesses to the accident?

Yes No If yes, please give names and address

Has a claim been made against you?

Yes No If yes, indicate whether: Verbal In writing (please attach correspondence)

Has any payment or agreement been made to any person(s)?

Yes No If yes, please give details

Details of Injuries

Name of Injured Person: _____

Approximate Age: _____ Male Female

Address of injured person: _____

_____ Phone Number: _____

Nature of injuries

Personal Injury Details

Part of Body Injured (Please tick appropriate box)

- | | | |
|---------------------------------------|--------------------------------------|--|
| <input type="checkbox"/> Head & Neck | <input type="checkbox"/> Hip | <input type="checkbox"/> Hands/Fingers |
| <input type="checkbox"/> Eyes or Face | <input type="checkbox"/> Shoulder | <input type="checkbox"/> Knee |
| <input type="checkbox"/> Back & Trunk | <input type="checkbox"/> Arms/Wrists | <input type="checkbox"/> Feet & Toes |

If Other, or multiple, please describe:

Nature of Injury (Please tick appropriate box)

- | | |
|---|--|
| <input type="checkbox"/> Multiple | <input type="checkbox"/> Concussion/Unconscious (serious) |
| <input type="checkbox"/> Minor Bruise – Not disabling | <input type="checkbox"/> Major Bruising – Disabling |
| <input type="checkbox"/> Fracture | <input type="checkbox"/> Sprain |
| <input type="checkbox"/> Burns/Scalds – requiring medical attention | <input type="checkbox"/> Superficial |
| <input type="checkbox"/> Minor Cut/Laceration – No Stitch | <input type="checkbox"/> Cut/Laceration requiring stitches |
| <input type="checkbox"/> Dislocation | <input type="checkbox"/> Ligament Damage |
| <input type="checkbox"/> No Apparent Injury | <input type="checkbox"/> Minor Concussion |

If Other, please describe:

Description of, and sequence of events leading up to the incident (as described by injury party)

Description of incident (by you or independent witness)

Was the injured person:

- | | |
|--------------------------|--------------------------|
| <input type="checkbox"/> | Treated by First Aider |
| <input type="checkbox"/> | Taken to Doctor/Hospital |
| <input type="checkbox"/> | Taken by Ambulance |

Name of First Aider/Person attending:

Contact Number:

Other (please describe):

If Third Party/Contractor at fault, state

Third Party/Contractors Name:

Third Party/Contractors Insurance Details:

Details of Property Damage

Name of owner of damaged property:

Address of owner of damaged property:

_____ Phone Number: _____

What was damaged?

Where can the damaged property be inspected?

Please attach all quotations obtained for replacement of or repair to the damaged property.

Location of Incident (please tick in appropriate box)

Shop No. of Nearest Tenant: _____

Car Park Ramps

Entrance/Exit

Escalators

Toilet Areas

Common Areas – Food

Common Areas – Non Food

Office Areas

Internal Ramp

Childrens Play Area

Car Parks

Stairs

Moving Walkway

Elevators

Restaurants

Other

If Other, please describe: _____

Type of Incident (please tick in appropriate box)

Reason for slip and fall of person:

- | | | |
|---|--|--|
| <input type="checkbox"/> Chips | <input type="checkbox"/> Lack or Barrier | <input type="checkbox"/> Uneven Floor |
| <input type="checkbox"/> Ice Cream | <input type="checkbox"/> Rainwater on floor | <input type="checkbox"/> Tripped over object |
| <input type="checkbox"/> Beverage | <input type="checkbox"/> Barrier/Signs | <input type="checkbox"/> Steps/Stairs |
| <input type="checkbox"/> Floor Slippery (surface) | <input type="checkbox"/> Vegetable/Fruit items | <input type="checkbox"/> Car Park Bollards |
| <input type="checkbox"/> Inadequate lighting | <input type="checkbox"/> Other food | <input type="checkbox"/> No apparent reason |
| <input type="checkbox"/> Person running | <input type="checkbox"/> Vomit | |

If Other, please describe:

Type of Surface:

- | | | |
|-------------------------------------|--|---------------------------------|
| <input type="checkbox"/> Marble | <input type="checkbox"/> Tile | <input type="checkbox"/> Carpet |
| <input type="checkbox"/> Speed hump | <input type="checkbox"/> Terrazzo | <input type="checkbox"/> Timber |
| <input type="checkbox"/> Bitumen | <input type="checkbox"/> Dirt/Grass/Garden | <input type="checkbox"/> Slate |
| <input type="checkbox"/> Vinyl | <input type="checkbox"/> Concrete | <input type="checkbox"/> Other |

If Other, please describe

Caught in:

- | | | |
|-------------------------------|---|------------------------------------|
| <input type="checkbox"/> Door | <input type="checkbox"/> Escalator/Elevator | <input type="checkbox"/> Machinery |
|-------------------------------|---|------------------------------------|

If Other, please describe

Was the injured person:

- | | | |
|-------------------------------------|--------------------------------|-------------------------------------|
| <input type="checkbox"/> Reasonable | <input type="checkbox"/> Upset | <input type="checkbox"/> Aggressive |
|-------------------------------------|--------------------------------|-------------------------------------|

Add relevant comments:

Name of Cleaner on Duty:

(if applicable)

Name of Cleaning Supervisor:

(if applicable)

Time location last inspected:

Time last cleaned:

Please attach a written statement from the cleaner (if appropriate)

Record of Incident:

- | | | |
|---|--------------------------------|-------------------------------|
| <input type="checkbox"/> Video/Closed circuit | <input type="checkbox"/> Photo | <input type="checkbox"/> None |
|---|--------------------------------|-------------------------------|

Claims Experience – Last Five Years

Date of Loss	Description	Incurred Amount
_____	_____	\$ _____
_____	_____	\$ _____
_____	_____	\$ _____
_____	_____	\$ _____
_____	_____	\$ _____
_____	_____	\$ _____
_____	_____	\$ _____
_____	_____	\$ _____
_____	_____	\$ _____
_____	_____	\$ _____

Please attach a separate page if insufficient space provided

Declaration and Authorisation

The information and answers given above are true in every detail. No information has been withheld. I understand that the claim may be refused if information is withheld or false, misleading, untrue or concealed. I authorise that Millennium Underwriting Agencies Pty Ltd give to and obtain from other insurers, insurance reference bureaus and credit reporting agencies any information relating to the Insured's credit or insurance history as well as insurance claims information obtained during the course of this contract.

Signature of each insured

_____/_____/_____
Date

Witness

_____/_____/_____
Date