

LIABILITY CLAIM FORM

IMPORTANT NOTE

THIS FORM MUST BE COMPLETED BY THE POLICYHOLDER NOT THE INJURED PARTY

TO BE COMPLETED WHEN ACCIDENT CAUSES DAMAGE TO PROPERTY OR INJURY TO A MEMBER OF THE PUBLIC

(If there is not enough room on this form for your answers, please attach a separate sheet, indicating the Section and Question you wish to complete).

YOUR PRIVACY

The Privacy Act 1988 requires us to make the following disclosure before collecting personal information about you:

- We collect personal information in order to provide our broking services including assistance with insurance claims. We will ask you to supply personal information on this form so we can assist you to submit your insurance claim and have it considered by the insurer. We will disclose this information to the insurer for this purpose.
- If the personal information is not provided, the insurer may not be able to assess and pay the claim and we may not be able to assist with your claim.
- We and the insurer may disclose the personal information to other people involved in reviewing the claim, including reinsurers, other insurance intermediaries, the insurer's advisors such as loss adjusters, lawyers and accountants, and other parties involved in the claims handling process.
- Your information will be disclosed to organisations overseas if your policy is underwritten by an overseas insurer. If your insurer is overseas, information about where the insurer is located is set out below:

Further information about how to access the personal information we hold about, have it updated or corrected or how to make a complaint about how your personal information is in our Privacy Policy on our website: <http://www.pauldonnellybrokers.com.au/privacy-policy/>

CONTACT US

You can contact our Privacy Officer using the details below:

Privacy Officer – Samantha Donnelly
Paul Donnelly Insurance Brokers Pty Ltd
Mail: PO Box 97, Berowra NSW 2081
Location: Suite 1, Jubilee Towers, 107 Pacific Highway, Hornsby NSW 2077
Tel: 02 9482 7422 Fax: 02 9482 7462
Email: pdib@pauldonnellybrokers.com.au

| |
|----------------------|
| Claim Number: |
|----------------------|

1. DETAILS OF POLICY HOLDER

| | |
|-----------------------------------|----------------|
| Full Name(s) of Insured: | |
| | |
| Address of Insured: | |
| | |
| Contact Telephone Numbers: | Mobile |
| | Business Hours |
| | After Hours |
| | Email |

| | | |
|-----------------|-------------------|---------------------|
| Insurer: | Policy No: | Expiry Date: |
| | | |

| | |
|-----------------------------|------|
| Occupation or Trade: | |
|-----------------------------|------|

2. DETAILS OF ACCIDENT / INJURY

| | | | |
|--------------------------|-----|--------------------------|-------|
| Date of accident: | / / | Time of accident: | am/pm |
|--------------------------|-----|--------------------------|-------|

| | | |
|---------------------------------------|--|---|
| Was there any personal injury? | <input type="checkbox"/> YES <input type="checkbox"/> NO | <i>If yes, please advise names & addresses of Injured Person(s)</i> |
|---------------------------------------|--|---|

| Name(s) | Address(es) including contact number |
|----------------|---|
| | |
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|---------------------------------------|---|
| Nature and extent of injuries: | 1 |
| | 2 |

| | |
|--|---|
| Name of doctor and/or hospital (if applicable): | 1 |
| | 2 |

| | |
|---|--|
| Was any Third Party Property Damage? | <input type="checkbox"/> YES <input type="checkbox"/> NO |
|---|--|

If yes, please advise Name of Third Party, Address, Contact Number and details of Property Damaged

| | | | |
|-------------------------------|-----|--|--|
| Is the third Party ? : | i | An employee of the Policy Holder ? | <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 Policy Holders Family ? | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| | iv | Ordinarily a Resident in the Policy Holders Home ? | <input type="checkbox"/> YES <input type="checkbox"/> NO |

| | |
|---------------------------------------|--|
| Has the Claim been Initiated : | Verbally <input type="checkbox"/> YES <input type="checkbox"/> NO <i>If yes, who did you advise</i> |
| | In Writing <input type="checkbox"/> YES <input type="checkbox"/> NO <i>If yes, please attach correspondence</i> |

| | |
|--|--|
| Name of your Employee in charge at the time of the Accident / Incident: | |
|--|--|

| Please provide Details of All Witness(es) : | Name(s) | Address(es) including contact number |
|--|----------------|---|
| | | |
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| Please provide Full Circumstances surrounding the Accident Incident : | |
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3. ABN DETAILS

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| Are you a Registered Business? : | <input type="checkbox"/> YES <input type="checkbox"/> NO |
|---|--|

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| Please advise your Australian Business Number [ABN]: | |
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| | |
|---|---|
| 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

[Company Name]

in the event of any action or matter that may be taken by any party pursuant to the Privacy Act 1988 (Cth). I/We acknowledge that I/we have read and understood the paragraphs accompanying this proposal headed "Your Privacy".

| | |
|---|--|
| Full Name of Claimant(s): PLEASE USE BLOCK LETTERS | |
|---|--|

| | | | |
|---------------------|--|----------------|--|
| Signature(s) | | Dated : | |
|---------------------|--|----------------|--|

| | | | |
|---------------------|--|----------------|--|
| Signature(s) | | Dated : | |
|---------------------|--|----------------|--|

Payment Details for Electronic Funds Transfer (EFT) of Claim Settlement Should your claim be covered by the terms and conditions of your policy with us, we require you to complete the following fields in order for us to make payment on the claim.

By supplying this information you are directing us to make any payments in this claim to the account nominated below until you notify us in writing otherwise. We collect, use and disclose your personal information in accordance with privacy legislation and our Privacy Policy.

If you wish to obtain further information about how your personal information is being handled by us, please advise us when returning this form to the email address shown below.

In order to avoid delays in payment processing, please ensure the details provided in this form are accurate

4. BANK DETAILS

| | | | |
|-------------------------|--|---------------------|--|
| Account Number : | | BSB Number : | |
|-------------------------|--|---------------------|--|

| | | | |
|----------------------|--|-----------------------|--|
| Account Name: | | Name of Bank : | |
|----------------------|--|-----------------------|--|

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| Email for Payment Advice Notification : This is the address we will email when payment has been made | |
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