

Liability Claim Form

IMPORTANT NOTICE

This form must be completed by the Insured only and not the third party.

- Please answer all questions. This will help us process your claim quickly.
- If you need more space to answer any of the questions, please use a separate sheet of paper. Any attachments will form part of this claim report and the declaration will include them.

1. Policy number	Expiry date	You can find the information for question 1 on your policy or renewal schedule.
<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text" value="/ /"/>	
2. Insured name		
<input style="width: 100%;" type="text"/>		
3. Are you registered for GST purposes?		
No <input type="checkbox"/> Yes <input type="checkbox"/>	What is your ABN?	<input :="" :"="" style="width: 100%;" type="text" value":=""/>
Have you claimed or do you intend to claim an input tax credit on the GST applicable to this policy?		
No <input type="checkbox"/> Yes <input type="checkbox"/>	Is the amount claimed or intend to claim less than 100% of the GST applicable to the premium?	No <input type="checkbox"/> Yes <input type="checkbox"/> Specify the percentage amount claimed or intend to claim <input style="float: right;" type="text" value="%"/>

Claim Details

4. When did the injury/ damage/ loss happen?	Date	Time
	<input style="width: 100%;" type="text" value="/ /"/>	<input style="width: 100%;" type="text" value="am/pm"/>
5. Address / location where the injury/ damage/ loss happened		
<input style="width: 95%;" type="text"/>		Postcode
6. What does the claim relate to? (please tick box): Personal Injury <input type="checkbox"/> Property Damage/Loss <input type="checkbox"/>		
7. Injury/ Damage/ Loss Details		
Contact details of the injured person or the owner of the damaged/lost property		
Name	Telephone No.	
<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text" value="()"/>	
Address		
<input style="width: 95%;" type="text"/>		Postcode
Describe what happened		
<input style="width: 100%; height: 20px;" type="text"/>		
<input style="width: 100%; height: 20px;" type="text"/>		
<input style="width: 100%; height: 20px;" type="text"/>		
Describe the injury/ damage/ loss		
<input style="width: 100%; height: 20px;" type="text"/>		
<input style="width: 100%; height: 20px;" type="text"/>		
Was medical assistance necessary?		
No <input type="checkbox"/> Yes <input type="checkbox"/>	Doctor <input type="checkbox"/> Ambulance <input type="checkbox"/> Hospital <input type="checkbox"/>	<input style="width: 100%;" type="text"/>
		Name of Doctor/Hospital
Estimated cost of injury/ damage/ loss:		\$ <input style="width: 100%;" type="text"/>

see overleaf

9. Who reported the injury/ damage/ loss to you?

Name	Telephone No.
<input type="text"/>	()
Address	
<input type="text"/>	
Postcode	
<input type="text"/>	
When was it reported?	
<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="text"/> am/pm

10. Were there any witnesses?

No Yes ▶

Name & address of witness	Telephone No.
<input type="text"/>	()
<input type="text"/>	
Postcode	
<input type="text"/>	

11. Were the police notified in relation to the injury/ damage/ loss?

No Yes ▶

Officer's name	Name of station
<input type="text"/>	<input type="text"/>

12. a) Was the injury/ damage/ loss caused by a defect or hazard on the property where the injury/ damage/ loss occurred?

No Yes ▶ How long had you been aware of it?

b) Had anyone notified you of the defect or hazard before the injury/ damage/ loss?

No Yes ▶

When were you notified?	Who notified you?
<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="text"/>

▶ What details were given?

▶ What steps had been taken before the injury/ damage/ loss to rectify the defect or hazard?

c) Do you consider you are liable?

No Yes ▶ Why?

Declaration

I declare that to the best of my knowledge and belief all the information in this form is true and correct and I have not withheld any relevant information.

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

Name

Date

 / /
()

Contact Telephone No.

Please indicate the number of additional pages attached to this claim report

When complete, please forward this claim report to Strata Unit Underwriters

Mail: 5/263 Alfred Street North Sydney NSW 2060

Email: info@stratainsurance.com.au Fax: 1300 668 166