

LIABILITY CLAIM FORM

Contractors Bonding Limited / Dominion Underwriting Agents Pty Ltd

Insured:	Policy Number:
Location of Incident:	
Date of Incident:	Time of Incident:
Date Reported:	Time Reported:
Incident report completed by:	Incident reported to:
Time Incident Location inspected:	Inspected by:

PART 1 - INJURED PERSON DETAILS

Was any person injured as a result of the incident for which you are claiming? Yes No

If 'No' go to Part 2 - Witness Details

Surname:	Given Names:	
Address:		
Telephone No: Home:	Business:	Mobile:
Date of Birth:	Male <input type="checkbox"/>	Female <input type="checkbox"/>
Description of Injury:		
Was medical assistance required? Yes <input type="checkbox"/> No <input type="checkbox"/>	If 'Yes' Doctor <input type="checkbox"/> Ambulance <input type="checkbox"/> Hospital <input type="checkbox"/>	
Name of Doctor / Hospital:		

PART 2 - WITNESS DETAILS

Was any person witness to the incident for which you are claiming? Yes No

If 'No' go to Part 3 - Description of Incident

ATTACH STATEMENTS FOR ADDITIONAL COMMENTS

Surname:	Given Names:	
Address:		
Telephone No: Home:	Business:	Mobile:
Date of Birth:	Male <input type="checkbox"/>	Female <input type="checkbox"/>
(If more than one witness, please attach details)		
IF ANOTHER PARTY IS RESPONSIBLE, PLEASE PROVIDE DETAILS		

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PART 3 - DESCRIPTION OF INCIDENT

Did the police attend the incident? Yes <input type="checkbox"/> No <input type="checkbox"/>	If 'Yes' please provide Officers Name and Station
Officers Name:	Name of Station:
Is there any other insurance which might apply to this claim? Yes <input type="checkbox"/> No <input type="checkbox"/>	
If 'Yes' Please provide details and attach a copy of the contract	

PART 4 - PROPERTY DAMAGE

Was any property damaged as a result of the incident for which you are claiming? Yes <input type="checkbox"/> No <input type="checkbox"/>	
If 'No' go to Declaration	
Name and address of the owner of the damaged property	
Name:	
Address:	Post Code:
Estimated cost of repair or replacement: \$	

DECLARATION

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

I consent to Contractors Bonding Limited using my personal information I have provided on this form for the purpose of processing my claim. I understand that if I choose not to provide the required details, this is my choice, however, Contractors Bonding Limited may not be able to process my claim.

I consent to Contractors Bonding Limited disclosing my personal information to other insurers, an insurance reference service or as required by law. I consent to Contractors Bonding Limited also disclosing my personal information to and/or collecting additional information about me, from investigators or legal advisors.

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

Signature: _____ Date: _____

Print Name: _____