



Public / Products Liability Incident Report

The completion of this form is to report:

- Any accident which has caused bodily injury or property damage; or
- Any accident which has the potential to result in a personal injury or property damage claim.

If you have received any written communication, do not answer. Attach to this claim.

Claim number _____ (Office Use Only)

Name of insured _____

Occupation _____

Contact person _____

Home phone no. () _____ Work phone no. () _____ Mobile no. _____

Email _____

Postal address _____

_____ Postcode _____

Broker/agent name _____ Phone no. () _____

Policy No. _____ Excess \$ _____

Inception date ____ / ____ / ____ Expiry date ____ / ____ / ____

G.S.T.:

Are you registered for GST purposes? Yes No A.B.N. _____

To what extent are you entitled to claim an Input Tax Credit on the GST for this policy? _____ %

Premises leased? Yes Have premises been altered since incident? Yes No

If yes, give details _____

Incident / Accident:

Date ____ / ____ / ____ Time _____ am/pm Date reported ____ / ____ / ____

Location _____

Purpose for which location was being used _____

Who was the incident reported to? _____ Employee Yes No

Describe the incident (including the cause and source of information) _____

Products Liability:

If applicable, please complete the following)

Product name _____ Model No. _____

Serial No. _____ Lot No. _____ Batch No. _____

Customer's name _____ Phone No. _____

Address _____

_____ Postcode _____

Property damaged:

Nature and extent of damage _____ Estimated cost \$ _____
Name of owner of damaged property _____
Address _____

Postcode _____
Home phone no. () _____ Work phone no. () _____ Mobile no. _____

Personal injury:

Name of person injured _____
Age _____ years Sex Male Female Occupation _____
Address _____

Postcode _____
Home phone no. () _____ Work phone no. () _____ Mobile no. _____
Nature of injury _____
Was treatment given at the scene of the incident? Yes No
If Yes, by whom (if ambulance or doctor, give details) _____
Address _____

Postcode _____
Was transport provided to hospital? Yes No

Witnesses:

Were there any witnesses to the event? Yes No (If yes, please complete the following)
Name _____
Address _____

Postcode _____
Home phone no. () _____ Work phone no. () _____ Mobile no. _____
Where was the witness? _____

Second witness:

Name _____
Address _____

Postcode _____
Home phone no. () _____ Work phone no. () _____ Mobile no. _____
Where was the witness? _____

Privacy:

The Privacy Act 1988 requires us to tell you that as an insurer we collect your personal and sensitive information in order to calculate your loss and entitlements, determine our liability, compile data and handle claims. When handling claims, we may have to disclose your personal and other information to third parties such as other insurers, reinsurers, loss adjusters, external claims data collectors, investigators and agents or other parties as required by law.

You have the right to seek access to your personal information and to correct it at any time. Please contact us on (02) 9966 8820 and advise us of the changes.

Declaration:

I/We certify that the information given in this form is truthful, accurate and complete. No information likely to affect this claim has been withheld. I/We understand that this claim may be refused if information is untrue, inaccurate or concealed.

I/We acknowledge that I/we have read and understood the Privacy Act 1988 information referred to above and consent to the collection, storage, use and disclosure of personal and sensitive information of all persons affected by this claim, with their approval. I/We acknowledge that if I/we do not agree to the collection of this personal and sensitive information then Allianz will be unable to process my/our claim.

Signature of Insured _____ Date ____ / ____ / ____