

# report of accident



**Note:** This form must be completed by the policyholder not by the injured party. To be completed when the accident causes damage to property or injury to a member of the public.

## Section 1 details of policyholder

Name of policyholder

Address

Postcode

Telephone Before Hours (  )

Telephone After Hours (  )

Occupation/Trade

Policy Number

ABN

ITC %

Location of Loss

## Section 2 details of accident/injury

Date of accident  /  /

Time of accident  am/pm

Was there any personal injury?  
No  Yes  Please state name(s) and address(es) of injured person(s)

**Injured Person 1**

Name of injured person

Address

Postcode

Nature and extent of injuries

Name of doctor and/or hospital (if applicable)

**Injured Person 2**

Name of injured person

Address

Postcode

## Nature and extent of injuries

## Name of doctor and/or hospital (if applicable)

## Was there any third party property damage?

No  Yes  Please state name(s) and address(es) of owner(s)

### Owner 1

Name of owner

Address

Postcode

## Nature and extent of property damage

### Owner 2

Name of owner

Address

Postcode

## Nature and extent of property damage

## Is the third party

- An employee of the policyholder? No  Yes
- An employee of a subcontractor? No  Yes
- A member of the policyholder's family? No  Yes
- Ordinarily a resident of the policyholder's home? No  Yes

