

Public/Products Liability Incident Report

AIB AUSTRALIA

Please complete this claim form and include;

- Supporting evidence relevant to this claim. Examples; Photos, quote for repair, invoices, reports, etc.
- If you require further assistance contact the claims team – 07 5409 4600
- Return all documentation via email to; claims@aibinsurance.com.au

GENERAL DETAILS

Broker's Reference No	<input type="text"/>		
Policy No	<input type="text"/>		
Expiry Date of policy	<input type="text"/>		
Insured / Company Name	<input type="text"/>		
Name of person for Contact	<input type="text"/>		
Telephone	<input type="text"/>	Fax	<input type="text"/>
Email	<input type="text"/>		
Address	<input type="text"/>	Postcode	<input type="text"/>
GST Details	Registered for GST	<input type="checkbox"/> Yes <input type="checkbox"/> No	ITC entitlements <input type="text"/> %
	ABN	<input type="text"/>	
Third Party			
Full Name	<input type="text"/>		
Postal Address	<input type="text"/>	Postcode	<input type="text"/>
Contact Number	<input type="text"/>	Age	<input type="text"/>

PARTICULARS OF ACCIDENT/INCIDENT

Date & Time incident occurred:	<input type="text"/>	Date & Time Reported to You:	<input type="text"/>
Location of Incident (Street, Suburb, P/Code)	<input type="text"/>	Postcode	<input type="text"/>
Purpose for which location was being used	<input type="text"/>		
Company Employee to whom incident Reported	<input type="text"/>		
Please tell us what happened providing as much detail as possible	<input type="text"/>		

PRODUCTS LIABILITY – (If applicable, please complete the following)

Product Name	<input type="text"/>	Model No.	<input type="text"/>
Serial No.	<input type="text"/>	Batch No.	<input type="text"/>
Customers Name	<input type="text"/>	Customers Address	<input type="text"/>

PROPERTY DAMAGE – (If applicable, please complete the following)

Nature and Extent of Damage	<input type="text"/>		
Estimated Cost	<input type="text"/>		
Name of Owner of Damaged Property	<input type="text"/>		
Address Details	<input type="text"/>	Postcode	<input type="text"/>
Telephone Details	<input type="text"/>		

PERSONAL INJURY – (If applicable, please complete the following)

Name of Person Injured	<input type="text"/>		
Occupation	<input type="text"/>		
Age	<input type="text"/>	Sex	<input type="checkbox"/> Male <input type="checkbox"/> Female
Address	<input type="text"/>	Postcode	<input type="text"/>
Telephone	<input type="text"/>	Email	<input type="text"/>
Nature of Injury	<input type="text"/>		
Was treatment given at the scene of the incident?			<input type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, by whom – Name, Address and Contact Details:			
<input type="text"/>			
Was transport provided to Hospital?			<input type="checkbox"/> Yes <input type="checkbox"/> No

WITNESSES

Were there any witnesses to the event? Yes No

If Yes – (please advise relationship, employee, family etc)

Witness 1 Name, Address & Contact Details	Name	Address
	<input type="text"/>	<input type="text"/>
	Contact Details	<input type="text"/>
Where was the Witness	<input type="text"/>	
Witness 2 Name, Address & Contact Details	Name	Address
	<input type="text"/>	<input type="text"/>
	Contact Details	<input type="text"/>
Where was the Witness	<input type="text"/>	

POLICE

Did a Police Officer attend the accident / incident?

Yes No

If Yes name of Police Officer & Police Station

Did Police lay any charges or indicate action may be taken?

Yes No

If Yes please supply full details

SIGNATURE & 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.

Signature of Applicant

Date

SETTLEMENT BY DIRECT DEBIT

Some Insurers offer settlement by Direct Debit into your Bank Account.

If this option is available with your insurer and you wish to take this option please provide your bank account details below.

Account Name

Bank

BSB

Account Number