Broadform Liability Report
PI/BL Combined Policy

- **Please do not include any statement or comment on this form which could be construed as an admission of fault.**
- **Please attach any supplementary information and relevant correspondence.**

Insured's details

1. Name(s) of the Insured

2. **Are you registered for GST purposes?**

No ☐ Yes ☐ What is your ABN? : : : : : : : : : :

3. (a) Are you entitled to an Input Tax Credit on 100% of the GST paid on your insurance premium?

No ☐ Yes ☐

(b) Is your entitlement 100%? Yes ☐ No ☐ Please specify your percentage entitlement %

4. Insured's address

Postcode

5. Contact name | Telephone ( ) | Fax ( )

6. Policy number | Period of insurance From / / To / /

Claim details

7. When did the accident happen? Date / / Time am ☐ pm ☐

8. (a) Address where accident happened

(b) Are you the owner and/or occupier of the land or buildings at the address?

Yes ☐ No ☐ Name of owner/occupier | Address

9. Describe what happened

10. (a) Was the accident caused by a defect or hazard on the property where the accident happened?

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

(b) Had anyone notified you of the defect or hazard before the accident?

No ☐ Yes ☐ (a) When were you notified? / /

(b) Who notified you?

11 . Were there any witnesses?

No ☐ Yes ☐ Full name | Telephone number

Address

Full name | Telephone number

Address

12. Did the police attend the accident?

No ☐ Yes ☐ Officer's Name | Name of station

Please answer the questions on the next page, then read and sign the Declaration ☞

13. Have you received a claim from the injured person, or the owner of the damaged property?

No ☐ Yes ☐ Attach any correspondence relating to this claim.

14. What relationship exists between the the injured person, or the owner of the damaged property and you (e.g. client, visitor, employee)?

Property details

15. Describe the property and the damage.

16. Estimated cost of repair or replacement.

$

Injury details

17. (a) Name and Address of injured person

Name

Address

Postcode

(b) Occupation

Employer

(c) Age

Male ☐ Female ☐

Private telephone no.

Business telephone no.

18. What were the injuries?

19. Was medical assistance necessary?

No ☐ Yes ☐ Doctor ☐ Ambulance ☐ Hospital ☐

Name of Doctor/Hospital

Declaration

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

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

I/we consent to CGU Insurance disclosing my/our personal information to other insurers, an insurance reference service or as required by law. I/we consent to CGU Insurance also disclosing my/our personal information to and/or collecting additional information about me/us, from investigators or legal advisors. Where I/we have provided information about another individual (for example, an employee or client), I/we declare that the individual has been or will be made aware of that fact and the contents of the Policy (which includes the section on "The way we handle your personal information").

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

Date / /

Claims Department
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