

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

