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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

State 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

State Postcode

Nature and extent of injuries

Name of doctor and/or hospital (if applicable)

Injured person 2

Name of injured person

Address

State Postcode

Nature and extent of injuries

Name of doctor and/or hospital (if applicable)

Section 2 – Details of accident/injury (continued)

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

State Postcode

Nature and extent of property damage

Owner 2

Name of owner

Address

State 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 ☐

Has the claim been intimated

Verbally? No ☐ Yes ☐ ▶ To whom?

In writing? No ☐ Yes ☐ ▶ Please attach correspondence.

Name of employee in charge at the time of the accident

Please give details of all the witnesses

Witness 1 name

Witness 1 address

State Postcode

Witness 2 name

Witness 2 address

State Postcode

Witness 3 name

Witness 3 address

State Postcode

Section 2 – Details of accident/injury (continued)

Witness 4 name

Witness 4 address

State Postcode

Witness 5 name

Witness 5 address

State Postcode

State fully and clearly the circumstances surrounding the accident

Signature

Date / /