

Millennium

Underwriting Agencies

Liability Claim Form

Liability Claim Form

Claims Procedure

This claim form is to be completed when Your Property has been lost, damaged, stolen or destroyed. It may be necessary for You to arrange urgent temporary repairs to protect Your Property.

It is necessary for You to complete all Sections of this claim form. Please answer all parts of the appropriate questions relevant only to the type of claim that You are lodging. If there is insufficient space provided for any information requested or to be supplied, please supply these details on a separate sheet and attach to the claim form.

Please attach (or promptly supply) where possible the original repair invoice or quotations with this completed form as well as any notices to the Police for Property lost or stolen or any Malicious Damage.

On receipt of the above We will assess and administer Your claim in accordance with Your Policy. We will also keep You informed of any other requirements should they be required and we will keep you advised on the progress on the processing of Your claim. If You have any queries on any of the information required on this form, please do not hesitate to contact Your Authorised Representative or Broker or Millennium Underwriting Agencies Pty Ltd

Privacy

Millennium Underwriting Agencies Pty Ltd respects your privacy and complies with the Privacy Act and the Australian Privacy Principles. A copy of our Privacy Policy is available at www.millennium.com.au

Complaints Procedure

If you do not agree with any decision we make in relation to the Policy, please write to us stating what you disagree with and why.

We will then resolve or attempt to resolve your complaint immediately, or we will refer the matter to our Internal Dispute Resolution Committee (IDRC). If you are not satisfied with a decision by the IDRC, the matter may be referred to an independent dispute resolution body, Financial Ombudsman Service (FOS), provided the matter falls within their jurisdiction.

Financial Ombudsman Service (FOS)
Freecall 1300 78 08 08
Post: GPO BOX 3, Melbourne Victoria 3001
Website: www.fos.org.au
Email: info@fos.org.au

The Insurance Contracts Act 1984 (as amended) requires you to provide all information which your insurer may reasonably require, and stipulates that any omission may adversely affect the cover under your Policy.

If you would like more information on your Duty of Disclosure (or any other aspect), please contact your Authorised Representative, Broker or Millennium Underwriting Agencies Pty Ltd

Important Notes

Please complete the claimant's section and have the medical certificate completed by the Doctor attending You. This form is not to be taken as an admission of liability or waiver of any rights by companies.

Client Details

Name of Insured:

Due Date:

Agent/Broker:

Policy Number:

Address:

Contact Name:

Contact Number:

Email:

Occupation:

Are you registered for GST purposes?:

What is your ABN?:

Yes No

Have you claimed, or are you entitled to claim an input tax credit on the GST component of the premium applicable to this policy?:

Yes No

If yes, will you be claiming an amount less than 100%?:

If yes, specify amount claimed (%):

Yes No

Are you entitled to claim an input tax credit for repairs or replacement of the item that has been lost or damaged?:

Yes No

If yes, will you be claiming and amount less than 100%?

If yes, specify tax credit amount claimed (%):

Yes No

Claim Details

Date and Time of the Accident:

Location of the Accident:

State fully and clearly the circumstances surrounding the accident:

Claim Details (continued)

In your opinion, was another person responsible for this event?:

Yes No

If yes, please give name, address and phone number:

Name:

Phone No.:

Address:

Relationship of injured person/property owner to the insured:

Is the property owner a relative, friend or contractor to the insured?:

Yes No

Were there any witnesses to the accident?:

Yes No

If yes, please give names and address:

Has a claim been made against you?:

If yes, indicate whether Verbal or in Writing:

Yes No

Verbal In Writing

Written Claim Correspondence (if applicable):

Claim Details (continued)

Has any payment or agreement been made to any person(s)?:

Yes No

If yes, please give payment details:

Details of Injuries

Name of injured person:

Approximate Age:

Gender:

Male Female

Address of injured person:

Contact number of injured:

Nature of injuries:

Personal Injury Details

Part of Body Injured:

Head & Neck Hip Hands/Fingers Eyes or Face
 Shoulder Arms/Wrists Knee Feet & Toes

If other, or multiple, please describe:

Personal Injury Details (continued)

Nature of Injury (tick all appropriate):

- | | |
|--|---|
| <input type="radio"/> Multiple | <input type="radio"/> Concussion/Unconscious (serious) |
| <input type="radio"/> Minor Bruise – Not disabling | <input type="radio"/> Major Bruising – Disabling |
| <input type="radio"/> Fracture | <input type="radio"/> Sprain |
| <input type="radio"/> Burns/Scalds – requiring medical attention | <input type="radio"/> Superficial |
| <input type="radio"/> Minor Cut/Laceration – No Stitch | <input type="radio"/> Cut/Laceration requiring stitches |
| <input type="radio"/> Dislocation | <input type="radio"/> Ligament Damage |
| <input type="radio"/> Minor Concussion | <input type="radio"/> No Apparent Injury |

If other injuries, please describe:

Description of, and sequence of events leading up to the incident (as described by injury party):

Description of incident (by you or independent witness):

Personal Injury Details (continued)

Was the injured person:

- Treated by First Aider Taken to Doctor/Hospital Taken by Ambulance

Name of First Aider/Person attending:

First Aider Contact Number:

State Third Party/Contractors Name:

Third Party/Contractors Insurance Details:

Details of Property Damage

Name of owner of damaged property:

Address of owner of damaged property:

Owner Phone Number:

What was damaged?:

Where can the damaged property be inspected?:

Location of Incident

Shop No. of Nearest Tenant:

Location:

- | | | | |
|---|---|---|-------------------------------------|
| <input type="radio"/> Car Park Ramps | <input type="radio"/> Common Areas – Non Food | <input type="radio"/> Stairs | <input type="radio"/> Entrance/Exit |
| <input type="radio"/> Office Areas | <input type="radio"/> Moving Walkway | <input type="radio"/> Escalators | <input type="radio"/> Internal Ramp |
| <input type="radio"/> Elevators | <input type="radio"/> Toilet Areas | <input type="radio"/> Childrens Play Area | <input type="radio"/> Restaurants |
| <input type="radio"/> Common Areas – Food | <input type="radio"/> Car Parks | <input type="radio"/> Other | |

If other type of incident, please describe:

Type of Incident

Reason for slip and fall of person:

- | | | | |
|---|--|---|---|
| <input type="radio"/> Chips | <input type="radio"/> Lack or Barrier | <input type="radio"/> Uneven Floor | <input type="radio"/> Ice Cream |
| <input type="radio"/> Rainwater on floor | <input type="radio"/> Tripped over object | <input type="radio"/> Beverage | <input type="radio"/> Barrier/Signs |
| <input type="radio"/> Steps/Stairs | <input type="radio"/> Floor Slippery (surface) | <input type="radio"/> Vegetable/Fruit items | <input type="radio"/> Car Park Bollards |
| <input type="radio"/> Inadequate lighting | <input type="radio"/> Other food | <input type="radio"/> Person running | <input type="radio"/> Vomit |
| <input type="radio"/> No apparent reason | | | |

If other type of incident, please describe:

Type of Surface:

- | | | | |
|--------------------------------|------------------------------|--------------------------------|---|
| <input type="radio"/> Marble | <input type="radio"/> Tile | <input type="radio"/> Carpet | <input type="radio"/> Speed hump |
| <input type="radio"/> Terrazzo | <input type="radio"/> Timber | <input type="radio"/> Bitumen | <input type="radio"/> Dirt/Grass/Garden |
| <input type="radio"/> Slate | <input type="radio"/> Vinyl | <input type="radio"/> Concrete | <input type="radio"/> Other |

If Other, please describe:

Type of Incident *(continued)*

Caught in:

Door Escalator/Elevator Machinery

If caught in other, please describe:

Was the injured person?:

Reasonable Upset Angry

Add relevant comments:

Name of Cleaner on Duty (if applicable):

Name of Cleaning Supervisor (if applicable):

Name of Cleaning Supervisor (if applicable):

Time last cleaned:

Record of Incident:

Video/Closed circuit Photo None

Claim Experience - Last Five Years

Date of Loss:

Description:

Incurred Amount:

<hr/>	<hr/>	\$
<hr/>	<hr/>	\$
<hr/>	<hr/>	\$
<hr/>	<hr/>	\$
<hr/>	<hr/>	\$
<hr/>	<hr/>	\$
<hr/>	<hr/>	\$

Declaration

I/We solemnly and sincerely declare:

That the information supplied on this Claim Form and Statement of Claim is true in every respect.

1. I/We understand that the claim may be refused if information is withheld, false, misleading or concealed
2. That there was no other insurance covering this loss current at the date of this incident.
3. I/We acknowledge that this Claim Form is a Legal Document and as such may be used in any legal proceedings resulting from this claim.

Submission

- By ticking this box, I acknowledge this declaration and acknowledge that the information I have supplied to be true and accurate to the best of my knowledge.

Please print name:

Signed:

Date:

/ /

Please complete and return this form to:

Millennium Underwriting Agencies Pty Ltd
PO Box 309 Kent Town SA 5071