SALON
INSURANCE
AUSTRALIA

LIABILITY CLAIM FORM

Claim Number:

1. Details of Policy Holder

Name of Policy Holder: ……………………………………………………… **Address of Policy Holder:** ……………………………………………………… ……………………………………………………… Postcode ………………	**Occupation or Trade:** ……………………………………………………… ……………………………………………………… **Telephone Numbers:** **Business Hour** (…..) ………………………..………………….. **After Hour** (…..) …………………………………………..	
Insurer: ………………………………………..	**Policy No:** ………………………………………..	**Expiry Date:** ……. / ………………… / 20……

2. Details of Accident / Injury

Date of accident:	…..... / …….. / 20…….	**Time of accident:** …………….. am/pm
Was there any personal injury? *If yes, please state:*	☐ YES ☐ NO	
(i) name(s) and address(es) of injured persons:	1. Name: …………………………………………………………………………. Address: …………………………………………………………………………. …………………………………….. Postcode ……………………….. 2. Name: …………………………………………………………………………. Address: …………………………………………………………………………. …………………………………….. Postcode ………………………..	
(ii) nature and extent of injuries:	1. …………………………………………………………………………………………. …………………………………………………………………………………………. 2.	

	……………………………………………………………………………………… ………………………………………………………………………………………
(iii) name of doctor and/or hospital (if applicable)	1. ……………………………………………………………………………………… 2. ………………………………………………………………………………………
Was any third party property damaged? *If yes, please state:*	☐ YES ☐ NO
(i) name(s) and address(es) of owner(s):	1. Name: …………………………………………………………………………… Address: …………………………………………………………………………… ……………………………………….. Postcode ………………………… 2. Name: …………………………………………………………………………… Address: …………………………………………………………………………… ……………………………………….. Postcode …………………………
(ii) nature and extent of damage:	1. ……………………………………………………………………………………… ……………………………………………………………………………………… 2. ……………………………………………………………………………………… ………………………………………………………………………………………
Is the third party:	(i) an employee of the policyholder? ☐ YES ☐ NO (ii) an employee of a sub-contractor? ☐ YES ☐ NO (iii) a member of the policyholder's family? ☐ YES ☐ NO (iv) ordinarily resident in the policyholder's home? ☐ YES ☐ NO
Has the claim been intimated:	(i) verbally? ☐ YES ☐ NO *(If yes, to whom)* …………………………………………………………………………………………… (ii) in writing?

<table>
<tr><td></td><td colspan="2">☐ YES ☐ NO *(If yes, please attach correspondence)*

……………………………………………………………………………………………………</td></tr>
<tr><td>**Name of your employee in charge at the time of the accident**</td><td colspan="2">……………………………………………………………………………………………………</td></tr>
<tr><td rowspan="2">**Give details of all witnesses, if any:**</td><td>**Name**</td><td>**Address**</td></tr>
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<tr><td colspan="3">**State fully and clearly the circumstances surrounding the accident:**

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3. ABN Details

Are you a registered business? ☐ Yes ☐ No
What is your ABN? ABN No: …………………………………...
What percentage of GST in your premium did you claim as an Input Tax Credit for the period of insurance in which this loss occurred? ……………..%

4. Declaration

I declare that the above statements are true, that I have not suppressed or mis-stated any facts. I expressly agree that the information given by me is provided with my full knowledge and consent and further agree to hold harmless and indemnify Direct Insurance Brokers in the event of any action or matter that may be taken by any party pursuant to the Privacy Act 1988 (Cth). Full name of claimant(s) *(please use block letters)* …………………………………………………… ……………………………………………………
Signature(s) …………………………………………………… Date: ….. / ……… / 20….. …………………………………………………… Date: ….. / ……… / 20…..