

# Professional Indemnity Claim Form



## NOTIFICATION OF CIRCUMSTANCES OUT OF WHICH A CLAIM MIGHT ARISE

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

<input type="text"/>			
INSURED			
<input type="text"/>			
POLICY NUMBER			
<b>YOUR DETAILS</b>			
<b>NAME</b>			
Full legal name of each incorporated body or natural persons including any business or trading names	<input type="text"/>	<input type="text"/>	
	<input type="text"/>	<input type="text"/>	
	<input type="text"/>	<input type="text"/>	
LEGAL NAME / BODY / PERSONS / TRADING NAME			
ABN			
<b>GST</b>			
Are you registered for GST?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tax Credits Claimed: <input type="text"/> %	
<b>ADDRESS</b>			
Insured's Address	<input type="text"/>	<input type="text"/>	
	NUMBER, STREET ADDRESS	CITY / SUBURB	
<input type="text"/>	<input type="text"/>		
STATE	POSTCODE		
<b>CONTACT DETAILS</b>			
<input type="text"/>	<input type="text"/>		
CONTACT NAME 1	CONTACT NAME 2		
<input type="text"/>	<input type="text"/>		
TELEPHONE NUMBER	MOBILE NUMBER		
<input type="text"/>	<input type="text"/>		
EMAIL	FAX		
<b>INSURANCE PERIOD</b>			
<input type="text"/>	<input type="text"/>		
DATE FROM (DD/MM/YY)	DATE TO (DD/MM/YY)		
<b>CLAIM DETAILS</b>			
Date when services rendered, out of which a Claim has been/might be made against the Insured	<input type="text"/>		
DATE (DD/MM/YY)			
Name of client you were retained by/contracted to and the specific nature of your duties under the retainer/contract	<input type="text"/>		
<b>DATE WHEN THE INSURED</b>			
(a.i) first became aware that there existed a set of circumstances which may result in a claim being made	<input type="text"/>	(a.ii) Please advise how this was originally communicated	<input type="text"/>
DATE (DD/MM/YY)			
(b.i) first received a notice of intention of any party to make a Claim	<input type="text"/>	(b.ii) Please advise how this was originally communicated	<input type="text"/>
DATE (DD/MM/YY)			

## CLAIM DETAILS

### COSTS

Your opinion of possible rectification costs OR potential amount of possible Claim

APPROX (\$) VALUE

### CLAIMANT

Name and details of claimant/potential claimant. If the claimant/potential claimant has legal representation, please provide details.

FIRST NAME

LAST NAME

NUMBER, STREET ADDRESS

CITY / SUBURB

STATE

POSTCODE

TELEPHONE NUMBER

MOBILE NUMBER

LEGAL REPRESENTATION DETAILS

Is the claimant a current client?

Yes  No

Have your fees been fully reimbursed, if not have you instigated recovery?

Yes  No

Do you have a good relationship?

Yes  No

Please disclose any further information about the above questions

Please provide a summary of the circumstances/ background to this notification

### LIABILITY

Please give your views on your potential liability

Liable  Possible  Not Liable

Please state why you think this

If you believe any other party may be liable, please provide details below including an estimate of any possible quantum

What risk management actions, if any, have you taken or intend to take as a result of this incident?

SHOULD ANY RESPONSES REQUIRE FURTHER ELABORATION, PLEASE CONTINUE ON A SEPARATE SHEET.

## DECLARATION

Contact details for Miramar Underwriting Agency are:

**Miramar Underwriting Agency Pty Ltd**  
Level 5, 97-99 Bathurst Street  
Sydney NSW 2000  
Phone +61 2 9307 6600  
Fax +61 2 9307 6699

I/ We hereby declare that:

The above statements are true, and I/ we have not suppressed or mis-stated any facts. I/ we understand that if I/ we choose not to provide the required details, this is my/ our choice, however, Miramar Underwriting Agency Pty Ltd may not be able to process my/ our claim.

I/ We authorize Miramar Underwriting Agency Pty Ltd, to collect or disclose any personal information relating to this insurance to/ from any insurers or insurance reference service or collecting additional information about me/ us, from investigators or legal advisors.

Where I/ we have provided information about another individual I/ we declare that the individual has been or will be made aware of that fact.

To be signed by the Chairman/ President/ Managing Partner/ Managing Director/ Principal of the association/ Partnership/ Company/ Practice/ Business.

Candidate

NAME

TITLE

SIGNATURE

DATE (DD/MM/YY)

NOTES

Large empty rectangular area for notes.