

PROFESSIONAL INDEMNITY REPORT FORM



Insurance Brokers

Certificate and Master Policy No: Insured:

Insured's Contact No:

Incident	Date of Incident: <input type="text"/> Time of Incident: <input type="text"/> When were you first notified? <input type="text"/>						
Incident Address	Address where Incident Occurred: <input type="text"/> <div style="text-align: right;">POSTAL CODE <input type="text"/></div> Telephone Number and Contact: <input type="text"/> Do you Own or Rent the Premesis? <input type="button" value="OWN"/> <input type="button" value="RENT"/> If renting, please attach a copy of any rental agreement.						
Details of Incident	State in detail exactly how the incident occurred: <i>(Please use a separate piece of paper if necessary)</i> <input type="text"/> <input type="text"/> <input type="text"/> Witness name and address, if any: <table border="1" style="width: 100%;"><thead><tr><th style="width: 30%;">NAME</th><th>RESIDENTIAL ADDRESS</th></tr></thead><tbody><tr><td><input type="text"/></td><td><input type="text"/></td></tr><tr><td></td><td style="text-align: right;">POSTAL CODE <input type="text"/></td></tr></tbody></table> Your qualifications - please attach: <input type="text"/>	NAME	RESIDENTIAL ADDRESS	<input type="text"/>	<input type="text"/>		POSTAL CODE <input type="text"/>
NAME	RESIDENTIAL ADDRESS						
<input type="text"/>	<input type="text"/>						
	POSTAL CODE <input type="text"/>						
Property Damage	Name and Address of owner: <table border="1" style="width: 100%;"><thead><tr><th style="width: 30%;">NAME</th><th>RESIDENTIAL ADDRESS</th></tr></thead><tbody><tr><td><input type="text"/></td><td><input type="text"/></td></tr><tr><td></td><td style="text-align: right;">POSTAL CODE <input type="text"/></td></tr></tbody></table> Description of damage: <input type="text"/> <input type="text"/> Estimate of damages caused: <input type="text"/>	NAME	RESIDENTIAL ADDRESS	<input type="text"/>	<input type="text"/>		POSTAL CODE <input type="text"/>
NAME	RESIDENTIAL ADDRESS						
<input type="text"/>	<input type="text"/>						
	POSTAL CODE <input type="text"/>						
Police	Police Ref. No. and Station: <input type="text"/> Date Reported: <input type="text"/>						
Relationship	If claimant is in your service, or your tenant, or related to you? <input type="button" value="YES"/> <input type="button" value="NO"/> If yes, please give full details: <input type="text"/> Was the claimant in good health? <input type="button" value="YES"/> <input type="button" value="NO"/>						
Personal Injuries	Name, address and age of person: <input type="text"/> Details of injuries: <input type="text"/>						
Declaration	Has a claim been made against you? <input type="button" value="YES"/> <input type="button" value="NO"/> If yes, please attach correspondence.						
Claim	I/We declare that to the best of my/our knowledge the above statements are truly made.						
Completed By	<table style="width: 100%;"><tr><td style="width: 33%;"><input type="text"/></td><td style="width: 33%;"><input type="text"/></td><td style="width: 33%;"><input type="text"/></td></tr><tr><td style="text-align: center;">SIGNATURE OF INJURED</td><td style="text-align: center;">NAME</td><td style="text-align: center;">DATE</td></tr></table>	<input type="text"/>	<input type="text"/>	<input type="text"/>	SIGNATURE OF INJURED	NAME	DATE
<input type="text"/>	<input type="text"/>	<input type="text"/>					
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