Public Liability
Claim Form

It is essential that this form be returned directly to Ansvar Insurance, with all questions answered, at the earliest opportunity.
Please print your answers and ✓ where appropriate. If insufficient room, please attach separate sheet.

Office use only Claim number

1. Policyholder details

Name/Business name

Policy number

Address

Postcode

Telephone: Home

Telephone: Work

Telephone: Mobile

Email

Occupation

2. Accident details

Date of accident / /

Time am/pm

Describe how and where the accident occurred

If insufficient room, please use space on back of form or attach separate sheet.

AD PO Box 7042, Wellesley St, Auckland 1141 FX 09 373 8859
Ansvar Insurance Ltd. Member of the Ecclesiastical Insurance Group
0800 123 344 **ansvar.co.nz**

3. Name and address of other party

Name

Address | Postcode | Telephone

Has a claim been made by other party? ☐ Yes ☐ No Have you admitted liability? ☐ Yes ☐ No

4. Was there a witness to the accident?

☐ Yes ☐ No *If yes, name and address of witness* Name

Address | Postcode | Telephone

5. Do you have a public liability policy with another insurer?

☐ Yes ☐ No *If yes, name and address of company* Name

Address | Postcode | Telephone

6. Electronic Funds Transfer Settlement of your claim may involve a cash settlement. Please complete the following if you are interested in an EFT Payment

Account name | Bank | Branch number | Account number | Suffix

7. Declaration/Privacy Act 1993/Insurance Claims Register

I/We declare that to the best of my/our knowledge and belief, these particulars are complete and correct.
I/We:

a. agree to give any further information that may be required
b. understand you require this personal information, which will be retained by you at 396 Queen Street, Auckland, before you can evaluate my/our claim
c. authorise the disclosure of this personal information regarding this claim to other parties
d. authorise the obtaining by you, from any other party personal information about me/us that is in your view relevant to this claim
e. authorise the obtaining by you, from Insurance Claims Register Limited (ICR Ltd), which holds details of claims made by me/us under polices with other insurers, personal information about me/us that is in your view relevant to this claim
f. authorise you to place details of this claim on the database of ICR Ltd, PO Box 474 Wellington, where it will be retained and available to other insurance companies to inspect
g. understand that I am/we are entitled to have certain rights of access and correction of the personal information held by you and ICR Ltd

The collection of this information is required under terms of your policy. Failure to provide it may result in your claim being declined.

Signature of the Policyholder(s) | Date

/ /

/ /

If the policy is in joint names, both signatures are required