CGU SEE IT THROUGH.

EMPLOYMENT PRACTICES LIABILITY

NOTIFICATION OF CIRCUMSTANCES OUT OF WHICH A CLAIM MIGHT ARISE

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

Insured's details

1. Name(s) of the Insured

2. Insured's address

Postcode

3. Contact name

Telephone no.

Email Address

4. Policy number

5. Period of insurance from D D / M M / Y Y to D D / M M / Y Y

6. Are you registered for GST purposes? No Yes What is your ABN?

7. a. Are you entitled to an Input Tax Credit on 100% of the GST paid on your insurance premium? No Yes

b. Is your entitlement 100%? Yes No Please specify your percentage entitlement %

Claim details

8. Date of incident out of which a Claim has been or might be made against the Insured. D D / M M / Y Y
If more than one, provide full details overleaf.

9. Date when the Insured:

a. first became aware that there existed a set of circumstances which may result in a Claim being made D D / M M / Y Y

b. first received a notice of intention of any party to make a Claim D D / M M / Y Y

10. Details of claimant/possible claimant

Name

Age

Gender

First day of employment D D / M M / Y Y Last day of employment D D / M M / Y Y

11. Have you received a demand for compensation?

No Go to Q12.

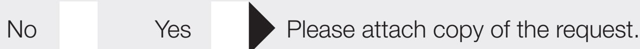
Yes was it a written demand? No Go to Q12.

Yes Please attach copy of the demand and go to Q13.

12. If no written demand has been received, please provide details of allegations anticipated to be made against the Insured.
If insufficient space, please continue in the section below.

Additional information in respect of Questions 8 and 12

13. Have you received a request to attend an Official Investigation or Inquiry into the circumstances notified in this report?



Section 5 - Insured/Policyholder declaration and acknowledgement

I declare that I am the person completing and executing this form and am authorised by the insured/policyholder to do so and that to the best of my knowledge and belief the information supplied by me herein is true and correct and I have not withheld any relevant information.

I agree that, by submitting this form, the personal information I provide to CGU Insurance Limited in this form or otherwise may be collected, held, used and disclosed in the manner set out in the CGU Privacy Policy found at www.cgu.com.au/privacy, including for processing this claim.

Signature of the insured or person with authority to sign for and on behalf of a company or partnership

Date DD / MM / YY

On completion of this form, please print and sign.
When ready, please return the form to CGU Claims via mail, fax or e-mail.

Claims Department
Level 12 181 William Street Melbourne VIC 3000
GPO Box 4609 Melbourne VIC 3001
Tel. (03) 9601 8709 Fax (03) 9602 5578
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