THE PRORISK GROUP
1300 776 467
enquiries@prorisk.com.au
www.prorisk.com.au

Healthcare Professionals

Civil Liability Claim Form

EMAIL

Please send all completed claims forms to: **newclaims@prorisk.com.au**

IMPORTANT NOTICE:

- This form is to be completed and signed by a Principal of the Insured when notifying a Claim or a fact or circumstance that has the potential to give rise to a Claim.
- All questions must be answered in full. If there is insufficient space, please provide further details on the Insured's letterhead.
- Please attach all relevant correspondence and documentation.

A INSURED

1. Name:

2. Address:

3. Contact person:

4. Telephone:

5. Email:

6. Policy Number:

7. Period of Insurance

From To

8. Broker:

9. Email:

10. Telephone:

11. Are you registered for GST purposes:

☐ YES ☐ NO

12. If **Yes to 11,** what is your ABN?

13. What percentage (if any) of GST on premium has been applied as an Input Tax Credit?

%

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B CLAIMANT / POTENTIAL CLAIMANT (THIRD PARTY)

1. Name:

2. Address:

4. Telephone:

5. Email:

6. Claimants Solicitors (if any):

7. Broker:

C INSURED'S RETAINER / CONTRACT

1. Who were you providing services to?

2. What services did you provide?

3. When did you perform the work out of which the Claim has arisen or may arise?

4. What is the name of the person who performed the work?

D INQUIRY BY YOUR PROFESSIONAL BODY

1. Have you received a letter from your overseeing professional body? (E.g. AHPRA, HCCC, OHO) ☐ YES ☐ NO

   *If **Yes,** please provide copies of all documentation received.*

2. Has a response been requested? ☐ YES ☐ NO

   *If **Yes,** when is your response due?*

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E CLAIM OR CIRCUMSTANCE

1. What has been claimed against you or what fact/circumstance might give rise to a Claim?

2. When did you first become aware of the Claim or the fact or circumstance that might give rise to a Claim?

3. When was the Claim or an indication of a Claim first made against you?

4. Was the Claim or an indication of a Claim made in writing? ☐ Yes ☐ No

5. What is the Claimant seeking from you? (I.e. Compensation, Refund of Fees, Apology, Cover for Medical Expenses). If a monetary figure has been claimed, please outline the amount below:

F YOUR COMMENTS

1. What are your comments in response to the Claim or in respect to the potential Claim?

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2. Do you have further information convering this matter, which may be of assistance to Insurers?
If so, please outline below:

PRORISK PRIVACY STATEMENT

The Privacy Act 1988 requires us to tell you that as an insurer we collect your personal and sensitive information in order to calculate your loss and entitlements, determine our liability, compile data and handle claims.

When handling claims, we may have to disclose your personal and other information to third parties such as other insurers, reinsurers, loss adjusters, external claims data collectors, investigators and agents or other parties as required by law.

You have the right to seek access to your personal information and to correct it at any time. Please contact us on 03 9235 5255 EST 9:00am-5:00pm, Monday-Friday and advise us of the changes.

DECLARATION

After making appropriate enquiries, I declare that:

- I am authorised on behalf of the Insured(s) to make this Declaration.
- The information in this Form is true and correct and I have not withheld any relevant information.
- I have read and understood the ProRisk Privacy Statement and I consent to ProRisk using the personal information in this Form for the purposes of investigating and handling any Claim or potential Claim against the Insured. I consent to ProRisk disclosing the personal information to third parties involved in the claims process, such as the Insurers, lawyers, claims adjusters and others appointed by ProRisk or by the Insurers.
- Where I have provided information about another individual, I declare that the individual has been made aware of that fact and of the ProRisk Privacy Statement.

Signature: _____

Name: _____

Position: _____

Date: _____