



Group Riders Personal Liability Insurance Claim Form

Issued by Agile Underwriting Services Pty Ltd
ABN 48 607 908 243 — AFSL 483374

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Coverholder at 

Section 1 – Insured’s Details

Policy Number:

1. Group Policyholder Name: (Including all trading names and legal entities)

ABN:

2. Riders Contact details:

Full Name:

Telephone number:

Mobile:

Email address:

Street Address:

City:

State:

Postcode:

Section 2 – Claim Details

3. Date of Incident: / /

4. Time of Incident:

AM
 PM

5. Date you first became aware of the incident:

 / /

6. Address where incident occurred:

Street Address:

City:

State:

Postcode:

7. Please provide a detailed description of the incident:

8. **Please provide details of any damaged property:**

9. **Please provide details of any injuries sustained:**

10. **Were emergency services contacted? (Police, Fire, Ambulance)** Yes No
If Yes, please provide full details and attach reports if available.

11. Did the incident involve the use of a e-scooter?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
12. Did the incident involve the use of a e-bike?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
13. Did the incident involve the use of a bicycle?	Yes <input type="checkbox"/>	No <input type="checkbox"/>

Section 3 – Claimant Details

14. **FullName:**

Address:

Street Address:

City:	State:	Postcode:
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Telephone number:

Mobile number:

Email address:

Section 4 – Witnesses

15. Witness 1 details:	Full Name:		
Street Address:			
City:	State:	Postcode:	
Telephone number:	Mobile:	Fax:	
Email address:			
16. Witness 2 details:	Full Name:		
Street Address:			
City:	State:	Postcode:	
Telephone number:	Mobile:	Fax:	
Email address:			

Declaration

Privacy Declaration

I/We agree that, by submitting this form, the personal information I/we provide to Agile in this form or otherwise may be collected, held, used and disclosed in the manner set out in our Privacy Policy, including for the processing of this claim. Yes

Declaration

I/We certify that the information given in this form is truthful, accurate and complete. No information likely to affect this claim has been withheld. I/We understand that this claim may be refused if information is untrue, inaccurate or concealed. Yes

Authority

I/We authorise any hospital and/or physician who has treated me to provide Agile with copies of medical records or of my past medical history, as requested. Yes

Name of Claimant: _____ Name of if Insured (if other than the claimant) _____

Signature: _____ Date: _____ / ____ / ____
(DD/MM/YY)