Group Riders Personal Liability Insurance

Claim Form

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

Powered by AGILE. Coverholder at LLOYD'S

Section 1 – Insured's Details

Policy Number:

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

Bird Australia Pty Ltd

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 ☐ No ■
12. **Did the incident involve the use of a e-bike?**	Yes ☐ No ■
13. **Did the incident involve the use of a bicycle?**	Yes ☐ No ■

Section 3 – Claimant Details

14. **Full Name:**

Address:
Street Address:

City:	State:	Postcode:

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) / /