LETTER OF DEMAND

MABLE LIABILITY CLAIM: LETTER OF DEMAND

POLICY NUMBER	INSURED	CLAIMS MANAGER	RETURN TO
408959DAA	**Mable Holdings Pty Ltd**	**DWF Claims**	**Your support worker**

For the person making the claim

Your support worker has given you this form because you have told them they are responsible for an injury or for damage to property.

Please complete and sign it, then give it back to your support worker, or email it to mable.aus@hmdi.com.au. The support worker will send it to their insurer with their claim.

Completing this form does not mean the claim will be accepted. The insurer will assess it and contact you if they need more information.

The grey notes under each question explain what it means.

1. YOUR DETAILS

The person asking the support worker to pay for the injury or damage.

Your full name

Your address
Street address, suburb, state and postcode.

Your phone number

Your email address

Who are you?

- The support worker's Mable client
- A family member of the client
- Someone else

If you are writing for someone else, their name and how you are related
For example: I am writing for my mother, Jane Smith.

2. THE SUPPORT WORKER

The person you say is responsible.

Support worker's full name

3. WHAT HAPPENED

Tell us in your own words. Simple words are fine.

Date it happened

Time it happened
Write the time, for example 3:30, then tick AM or PM.

AM PM

Address where it happened

What happened?
Tell us step by step what happened and what the support worker did.

4. YOUR CLAIM

What you are asking the support worker to pay for.

I am claiming for

An injury

Damage to property

Describe the injury or the damaged property
For an injury: what the injury is and any treatment. For property: what was damaged and how badly.

Amount claimed, if known
For example the repair quote, invoice or medical bills. Leave blank if you do not know yet.

$

I have attached

Repair quote or invoice

Photos

Medical reports or bills

Other documents

5. DEMAND AND SIGNATURE

I hold the support worker named above responsible for the injury or damage described in this form. I ask the support worker, or their insurer, to compensate me for it.

I declare that the information in this form is true and complete. I agree that HMD Insurance, DWF Claims and the insurers may use my information, and contact me, to assess this claim.

Your full name

Signature

Date