

## CLAIM FORM

Please complete this form and return it with all relevant documentation to the above address. This is to be completed by the Insured or a legal representative of the Insured.

### **A. DETAILS**

Name and Address of Insured:

Policy Reference:

Policy Type:

Inception Date:

Expiry Date:

### **B. CLAIM DETAILS**

Date of Loss:

Location of Loss:

Circumstances of Loss:

Value of Claim in Monetary terms:

### **Please attach documentation that may support your claim**

Are you claiming under any other policy in respect of this accident?

Yes / No

If yes, please give full name and address of Insurer

**DECLARATION I hereby declare that the above statements are true in every aspect.**

Claimant's signature

Date