

LIABILITY INSURANCE CLAIM FORM

The issuing of this form is not to be taken as an admission of Liability by the Insurer

1. Name and address of Insured	_____

Policy No.	_____
2. When did the loss or damage occur ?	Time : _____ Date : _____.
When was notice first given to the Insurer ?	To whom : _____ By Whom : _____.
3. Are they any witnesses ?	Yes _____ No _____
If so, please give names, professions and addresses	_____

4. Name of the claimant	_____
Address	_____

Phone / Fax No.	_____
5. Short description of loss circumstances	_____

6. Claim amount	<input type="checkbox"/> Bodily Injury Total _____.
	<input type="checkbox"/> Material Damage Total _____.

The Undersigned Insured declares that he has answered the above question conscientiously and truthfully

Issued at :

Date :

Signature :

