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GOODS IN TRANSIT CLAIM FORM

Policyholder Detail

Insured			
Address			
		Code	
Broker Name		Policy Number	
Cell		Tel Number	
Fax		Email	
Date of Loss		Time (AM-PM)	
Make of Vehicle		Model of Vehicle	
Registration Number Horse		Registration Number Trailers	
Description of goods carried			

New / Second Hand			New		
Address from which goods were dispatched					
				Code	
Date dispatched		Nature of Loss (e.g collision, hijack, overturning etc)			
Description of incident (attach driver's statement if possible)					

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Where did incident occur?		Current location of load?	
Contact name and number of person or insured in control of load			
Was the matter reported to the police?		Yes ◯	No ◯
Details of Officer		Station	
Date Advised		Case Number	
(A) Owner			
		Code	
(B) Insurers			
		Code	
Name and address of witness			
		Code	
Name and address of owners of goods			
		Code	
For whom were goods carried			
		Code	
Name and address of their insurers			
		Code	

Were you the principal contractor, or sub-contractor		Principal	◯	Sub-Contractor	◯
Did you or your employees	(A) Load the vehicle	☐	(B) Unload the vehicle	☐	
Did the consignees accept delivery			Yes ◯	No ◯	
If so, was a receipt given? (Attach Copy)			Yes ◯	No ◯	

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Did you use the Standard trading Conditions of Carriage					Yes	◯ No ◯
If not, what conditions of carriage did you use? (Please attach specimen copy)						
Has a claim been made against you by the owner?	Yes	◯	No	◯	Date received	

Particulars of goods lost or damaged

Quantity	Description	Value

Declaration

I / We hereby declare the forgoing particulars to be true and accurate in every respect.

Dated _____ / _____ / 20_____

Signed at _____ on this _____ day of _____ 20_____

Name: _____ Witnessed by: _____

Capacity: _____ Signature: _____