

General Third Party Liability Claim Form

Important Note - Please ensure Your Claim Form is completed in full and returned within 7 days after receipt. Failure to complete your form in full will result in the form being returned to you and will hold up the processing of your claim.

Policy no.: _____ Name of Insured: _____ Phone Contact No.: _____	Claim No.: _____ Address: _____ Email: _____
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Detail of Damage or Occurrence

When did the incident relating to the damage:	Time:	AM/PM.
Place and/or premises where it occurred :		
For what purpose were the premises occupied on the date of damage?		
What was the cause of damage, and how did it occur? Please give full details:		
Does the property in respect of which the claim is made belong to you?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Name of the owner of the property damaged due to the accident:	Phone no.:	
Address :		
Is there any bodily injury or death involved in the incident mentioned above? <input type="checkbox"/> Yes <input type="checkbox"/> No If reply Yes, please give their details.		
Name:	Contact Phone no.:	
Address :		

In case of bodily injury the present condition of the injured person, (please attach medical certificate)	
Is the injured person your employee? <input type="checkbox"/> Yes <input type="checkbox"/> No If reply Yes, please give their details.	
Do you consider yourself liable for the damage to the property?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If so, please give reason in details:	
Have you become liable for similar cause in the past?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If so, please give details:	
What is the estimated amount?	a) Property damage: US\$
	b) Bodily injury: US\$
Contact Person:	Phone no.:
Position :	Fax no.:

Insured Declaration

<u>Official Stamp:</u> Date:	I (We) confirm and certify that the above details are true and correct. <u>Signature:</u> Date:
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