

GOODS IN TRANSIT CLAIM FORM

Please provide the following information/documentation where possible with your claim form

- Quotation for repair/replacement
- Consignment/Freight/Delivery Note (showing Terms and Conditions)
- Packing/ Weight/ Inventory List
- Copy of your written letter of "Demand" to the carrier and their subsequent response
- Any other evidence of loss or damage i.e. photographs

INSURED DETAILS

Policy Number:		Claim Number:	
Insured Name:			
Postal Address:			
Contact Number:		Fax/Email address:	
Contact Name:		Mobile:	

GST DECLARATION

<input type="checkbox"/> Are you registered for GST Purposes?	Yes	No
<input type="checkbox"/> If Yes , what is your ABN? _____		
<input type="checkbox"/> Have you claimed an input tax credit on the GST amount applicable to this policy?	Yes	No
<input type="checkbox"/> Is the amount claimed less than 100%?	Yes	No
<input type="checkbox"/> If Yes , what percentage of the GST claimed is applicable to the premium? _____%		

CLAIM INFORMATION

1. Date of loss/damage: _____	Date of Dispatch: _____	Date of Arrival: _____
2. Place of Dispatch: _____	Place of Arrival: _____	
3. When was the loss/damage first discovered? _____ If any delay, why? _____		

4. Nature of claim - Please give full description of how loss/damage occurred?

5. Consignee Name and Address?

6. Consignor Name and Address?

7. Please describe packaging condition?

8. If known, where did the loss/damage occur?

9. If Goods are damaged, location of damaged Goods: _____

10. Has the event been reported to the police? **Yes** **No**
If **Yes**, please give details of the Police Station involved _____ Police Report no.: _____

11. If damaged goods cannot be repaired, is there Salvage Value? **Yes** **No**
If **Yes**, what is approx value AUD _____

12. Name and Address of other interested parties (i.e. Finance Company, Lessee)

13. Is there any other Insurance covering this event at the time of loss? **Yes** **No**
If **Yes**, please provide Company Name and policy number _____

If Goods transported by Carrier, please complete the following:

14. Name and Address of Carrier

15. Were details of the Loss and/or Damage noted at the time of delivery? **Yes** **No**
If **No**, please confirm reasons why? _____

16. Were details of Loss and/or Damage noted on delivery docket?	Yes	No
17. Has a claim been lodged on the carrier? (If No , please do so)	Yes	No

ITEMS TO BE CLAIMED (Include Make, Model and Age)	DETAILS OF LOSS/DAMAGE	Can the item be repaired? Yes/No	Amount Claimed (AUD)
<input type="text"/>	<input type="text"/>		_____
<input type="text"/>	<input type="text"/>		_____
<input type="text"/>	<input type="text"/>		_____
<input type="text"/>	<input type="text"/>		_____
<input type="text"/>	<input type="text"/>		_____
TOTAL AMOUNT CLAIMED			<input type="text"/>

EFT PAYMENT DETAILS:

(Please only complete this section if you require payment directly into your account)

Account Name: _____
Account Number: _____
Bank Name: _____
BSB Number: _____
Bank Address: _____
Overseas Payment: _____ **Swift Code:** _____
ABA Code: _____ **Sort Code:** _____

Declaration

The answers given to questions in this claim form may require further information to be requested and/or further investigations to be made by Associated Marine Insurers or parties appointed by them. This may include contacting the owner of the goods or livestock to obtain documentation to verify the amount and extent of the claim.

I declare that to the best of my knowledge and belief the information in this form is true and correct and I have not withheld any relevant information.

I consent to Associated Marine Insurers Agents Pty Ltd using my personal information I have provided on this form for the purpose of processing my claim. I understand that if I choose not to provide the required details, this is my choice, however, Associated Marine Insurers Pty Ltd may not be able to process my claim.

I consent to Associated Marine Insurers Agents Pty Ltd disclosing my personal information to other insurers, an insurance reference service or as required by law. I consent to Associated Marine Insurers Agents Pty Ltd also disclosing my personal information to and/or collecting additional information about me, from investigators or legal advisors.

I understand that Insurers do not admit liability by the issue of this form.

Signature of Insured: _____ **Dated:** _____ **Position:** _____