

**Western Australia Branch**  
 20 Kings Park Road., West Perth WA 6004  
 PO Box 205 West Perth WA 6972  
 Telephone: (08) 9320 5900  
 Facsimile: (08) 9324 1972

**CARGO CLAIM FORM**

**CLAIM NUMBER:** \_\_\_\_\_

**Please answer all questions in full. Any delay returning this form may prejudice your claim under the Policy.**

**ARE YOU REGISTERED FOR GST PURPOSES?**

No  Yes  ➤ What is your ABN? \_\_\_\_\_

Have you claimed an input tax credit on the GST amount applicable to this policy?

No  Yes  ➤ Is the amount claimed less than 100% of the GST applicable to the premium? No  Yes  ➤ Specify the percentage amount claimed \_\_\_\_\_ %

**INSURED (As per policy)** \_\_\_\_\_

**NAME OF CLAIMANT** \_\_\_\_\_

**ADDRESS OF CLAIMANT** \_\_\_\_\_ **TEL NO.** \_\_\_\_\_

**DETAILS OF SHIPMENT**

Insurance Policy No. \_\_\_\_\_ Issued by: \_\_\_\_\_

Vessel/Air \_\_\_\_\_ Voy. No. / Flight No. \_\_\_\_\_ Arrival date \_\_\_\_\_

Port of Shipment \_\_\_\_\_ Port of Discharge \_\_\_\_\_

**DETAILS OF CLAIM**

**Nature of claim** (Strike out if not applicable)

• Pilferage      • Shortlanded      • Damage - give brief description of circumstances of loss or damage,

\_\_\_\_\_

\_\_\_\_\_

LIST & DESCRIBE ITEMS CLAIMED FOR:	TYPE OF LOSS OR DAMAGE	INVOICE VALUE
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
(Claim will be adjusted on Insured Values)	<b>TOTAL</b>	\$ _____

**The following must be attached:**

- (1) Original Suppliers Invoice                      (2) Negotiable Copy Bill of Lading/Airway Bill                      (3) Wharf Delivery Docket  
(4) Any other evidence of loss or damage      (5) Original Insurance Certificate

Has a claim been lodged on the ship or other carrier? \_\_\_\_\_ If so attach copy, and reply if available.

*I hereby declare that my answers to the foregoing questions and particulars are to the best of my knowledge and belief true and correct.*

Signature of Claimant \_\_\_\_\_

Date \_\_\_\_\_ 20 \_\_\_\_