

GOODS IN TRANSIT (CARRIERS) CLAIM FORM

POLICY NUMBER: _____

Please answer all questions in full. Incomplete answers may delay processing of your claim.

Reference to you/your, I/We, my/our in this claim form means the Insured.

INSURED INFORMATION

Please advise

1. Name of Insured: _____
 Address: _____
 Phone: _____ Fax: _____ Mobile: _____

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

EVENT INFORMATION

1. Please give full details of the event giving rise to the claim which has been or may be made against you:

- 1.1. Date of loss: ___ / ___ / ___
- 1.2. Nature of claim (theft/damage etc): _____
- 1.3. Type of goods involved: _____
- 1.4. Where did loss occur: _____
- 1.5. When was the loss / damage first noticed: _____
- 1.6. Where can the damaged goods be inspected: _____
- 1.7. Owner of the damaged goods: _____
- 1.8. Contact details of the owner of the goods: Name: _____ Phone: _____
 Mobile: _____ Fax: _____ Other: _____
- 1.9. Other details: _____

2. In relation to the event:

- 2.1. Has the event been reported to the police? Yes No
 2.1.1. If YES please give details of the police station involved and names of attending officers: _____

(See over)

3. Were any third parties involved in the event? Yes No

3.1. If YES please advise names addresses and contact details if known: _____

CLAIM DETAILS

1. For the transit during which the event giving rise to the claim occurred were the goods being carried:

1.1. By you as a principal carrier? Yes No

1.2. by you as a subcontractor for another carrier: Yes No

If YES for whom were you carrying the goods? _____

1.3. By a subcontractor engaged by you? Yes No

If YES please give the name and address of the subcontractor: _____

2. Was a consignment note issued for the transit? Yes No

3. Was the consignment moved under a specific contract of carriage? Yes No

4. Has a claim been made against you by the owner of the goods or livestock? Yes No

If YES

4.1 What is the amount of the claim \$ _____ (attach a copy of the claim made against you.)

4.2 Do you require Associated Marine Insurers to:

Pay the claim as a goodwill payment? Yes No

Pay the claim because you believe to have a contractual obligation to do so? Yes No

Pay the claim because you have already agreed to settle it? Yes No

NOT pay the claim and defend the claim on your behalf? Yes No

If NO

4.3 Do you expect such a claim to be made against you? Yes No

5. Does the claim involve recoverable costs, which you have incurred? Yes No

If YES please supply invoices and accounts to support your claim.

IMPORTANT

Please attach all documentation supplied to you in support of the claim together with a legible copy of all issued consignment notes, contracts of carriage and any relevant specific contracts.

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.

We declare that my/our answers to the questions and other particulars stated in this claim form are to the best of my/our knowledge and belief true and correct.

Date: _____ Signed: _____

Position: _____