

Fire & Allied Perils 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.: _____	Claim No.: _____
Name of Insured: _____	Address: _____
Phone Contact No.: _____	Email: _____
Name & address of other Interested Parties (Hire, Purchase, Lease, etc.) if any.	
Is there any other Insurance in force which would cover this Loss occurrence in whole or in part?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If answer is Yes, Please advise with which Insurer.	
Name of Insurer:	Policy details:

Detail of Loss, Damage or Occurrence

Date of Fire/Loss/Damage/ Occurrence:	Time:	AM/PM.
When was Fire/Loss/Damage/Occurrence reported to you:	Time:	AM/PM.
Place and/or premises where it occurred :		
Please state full particulars of how the Fire/Loss/Damage occurrence took place:		
Please describe nature of damage:		

Responsibility/Witness

Was another person, in your opinion, responsible for the loss or damage because of the occurrence? If reply Yes, please give their details.	<input type="checkbox"/> Yes <input type="checkbox"/> No
Name:	Phone no.:
Address :	
Was there a witness to this event? If reply Yes, please give their details.	<input type="checkbox"/> Yes <input type="checkbox"/> No
Name:	Phone no.:
Address :	
Has the Fire/Loss been reported to Fire Brigade?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If answer is No, give reason:	

