

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.

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

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| 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 : | | |

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| 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

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| <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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