

Property All Risks 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.: _____ Name of Insured: _____ _____ Phone Contact No.: _____	Claim No.: _____ Address: _____ _____ Email: _____
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Detail of Loss, Damage or Occurrence

When did the Loss/Damage, Theft occur? :	Time: _____	AM/PM.
When was the Loss/Damage, Theft discovered? : By whom? :	Time: _____	AM/PM.
a) Place and/or premises where it occurred :		
Please state full particulars of how the Loss/Damage, Theft 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 : _____		
If you are claiming under the Risk of Damage, Housebreaking, Theft, Malicious, Baggage, provide details of occurrence: 		
Where were the police notified?	Time: _____	AM/PM

Police Station:	Police Officer's name:
State reason, if not reported to Police:	
When has the property last seen?	
At the time of loss, how long had the premises been unoccupied?	
If claiming for windstorm/Hurricane/Cyclone/Typhoon/Water Damage/Flood, advise the following:	
How did Wind Rain or Water enter into the premises?	
Did Hurricane/Cyclone/Typhoon cause opening to premises?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If answer is Yes, describe the cause or event:	

Legal Liability

Name of injured person or owner of damaged property :	Phone no.
Address :	
Is the injured person or owner of the damaged property in your employ, in the employ of any contractor or sub-contractor to you, or a relative to you?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If answer Yes, give details:	
Has any claim been made upon you?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If answer Yes, state details and attach :	

Insurance History

Have you ever previously claimed for a Loss/Damage/or caused Damage or Injury to Third Parties?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If answer Yes, give details of such losses and amounts involved:	
Was an Insurance company involved?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If answer Yes, please state below name of company and year of claim:	

