

# GOODS IN TRANSIT CLAIM FORM



## Insured

Name:	Policy No.:
Address:	Vat No.:
	Tel No.:
Code:	Business of Insured:

## Loss / Damage Details

Date of loss/damage:	Time:	AM <input type="checkbox"/>	PM <input type="checkbox"/>
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Description of goods concerned:

No. of packages:	Total weight:
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Description of loss:

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If goods were part only of consignment, describe nature of other goods and value:

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Address from which goods were despatched:

Code:

Date despatched:                      day/month/year

Reg No. of vehicle involved:	Make and type of vehicle:
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Was matter reported to police?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
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Details of Officer:	Police station:
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Date advised:                      day/month/year	Case No.:
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**Other Vehicle**

If another vehicle was involved.

Name of owner:	Insurers:
Address:	
Code:	

**Witnesses**

Name:	Tel No.:
Address:	
Code:	

**If You Are The Owner Of The Goods, Complete This Section**

How were the goods transported:

By whom:	Insurers:
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Have you advised them of the loss or damage? Yes  No

Date Advised:      day/month/year      **NB: CARRIERS SHOULD BE NOTIFIED OF ALL LOSSES WITHOUT DELAY**

Name of insurers:	Name of owners of the goods:
Address:	Address:
Code:	Code:

For whom were the goods carried:

Name of insurers:
Address:
Code:

Were you the...      Principle Contractor       Sub Contractor

Did you or your employees?      Load the vehicle       Unload the vehicle

Did the consignees accept delivery?      Yes       No

Did you use the Standard Trading Conditions of Carriage?      Yes       No

If NO, what conditions of carriage did you use (Please attach specimen copy):

Has a claim been made against you by the owner?      Yes       No

Date received:      day/month/year

Address where damaged goods can be viewed:
Code:

