



GOODS IN TRANSIT CLAIM FORM

INSURED

Name of Insured:

Physical Address:

Code

Postal Address:

Code

Policy No:

Vat No:

Business Ph No:

Cell No:

LOSS / DAMAGE DETAILS

Date of Loss/Damage:

Time:

Am

Pm

Description of goods concerned:

No of packages:

Total weight:

Description of loss:

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

Address from which goods were despatched:

Code

Date despatched:

Reg No. of vehicle involved:

Make and type of vehicle:

Was matter reported to police?

Yes

No

Details of Officer:

Police Station:

Date advised:

Case No:



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OTHER VEHICLE

If another vehicle was involved

Name of owner	Name of Insurer
Address	
Code	

WITNESSES

Name of owner:	Name of Insurer:
Address	
Code	

PARTICULARS OF GOODS LOST OR DAMAGED

How were the goods transported	
By whom?	
Have you advised them of the loss or damage?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Date advised	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 Principal Contractor? <input type="checkbox"/>	or the Sub-Contractor? <input type="checkbox"/>
Did you or your employees Load the vehicle? <input type="checkbox"/>	or Unload the vehicle? <input type="checkbox"/>
Did the consignees accept delivery?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Did you use the Standard Trading Conditions of Carriage?	Yes <input type="checkbox"/> No <input type="checkbox"/>
If NO what conditions of carriage did you use (Please attach specimen copy)?	
Has a claim been made against you by the owner?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Date received	
Address where damaged goods can be viewed	
Code	

PARTICULARS OF GOODS LOST OR DAMAGED

NOTE: All Invoices, Delivery Notes, Receipts and correspondence are to be sent with this form

QUANTITY	DESCRIPTION	VALUE
TOTAL		

DECLARATION

I / We warrant the truth of the answers to the above questions and I / We declare that no information has been withheld and / or that any misrepresentation has been made and that the amount claimed represents my / our loss arising from the above stated occurrence.

Signature of Insured

Date / /