# 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 ☐ 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: day/month/year

| | |
|---|---|
| Reg No. of vehicle involved: | Make and type of vehicle: |

Was matter reported to police? Yes ☐ No ☐

| | |
|---|---|
| Details of Officer: | Police station: |
| Date advised: day/month/year | Case No.: |

## *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:

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:**

## *Particulars Of Goods Lost Or Damaged*

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

| QUANTITY | DESCRIPTION | VALUE |
|---|---|---|
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| | **TOTAL** | |

## *Declaration*

I / We hereby declare the above particulars to be true in every respect.

| Signature of Insured: | Date: day / month / year |
|---|---|