

GOODS IN TRANSIT (CARRIERS) CLAIM FORM

Please provide the following information/documentation where possible with your claim form

- Documentation supplied to you in support of the claim
- Demands received from Owner of Goods
- Original Packing/ Weight/ Inventory List
- Consignment Note (including reverse side) and or Contracts of Carriage
- Invoices/accounts for recoverable costs i.e. removal of debris
- Any other evidence of loss or damage - photographs

INSURED DETAILS

Policy Number:		Claim Number:	
Insured Name:			
Postal Address:			
Contact Number:		Fax/Email address:	
Contact Name:		Mobile:	

GST DECLARATION

▪ Are you registered for GST Purposes?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
▪ If Yes , what is your ABN? _____				
▪ Have you claimed an input tax credit on the GST amount applicable to this policy?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
▪ Is the amount claimed less than 100%?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
▪ If Yes , what percentage of the GST claimed is applicable to the premium? _____%				

CLAIM INFORMATION

1. Date of loss/damage: _____	Date of Dispatch: _____	Date of Arrival: _____
2. Place of Dispatch: _____	Place of Arrival: _____	
3. When was the loss/damage first discovered? _____ If any delay, why? _____		

4. Nature of claim – Please give full description of how loss/damage occurred?

5. If known, where did the loss occur? _____

6. Type of Goods involved? _____

7. Where can damage goods be inspected? _____

8. Consignee Name and Address?

9. Consignor Name and Address?

10. Has the event been reported to the Police? Yes No

If **Yes**, please advise Police station: _____ Police Report no.: _____

11. Were any third parties involved in the event? Yes No

If **Yes**, please advise names addresses and contact detail if known:

For the transit during which the event giving rise to the claim occurred, were the goods being carried:

12. By you as a principal carrier? Yes No

13. By you as a subcontractor for another carrier? Yes No

If **Yes**, for whom were you carrying the goods? _____

14. By a subcontractor engaged by you? Yes No

If **Yes**, please give the name and address of the subcontractor:

15. Was a consignment note issued for the transit? Yes No

16. Was the consignment moved under a specific contract of carriage? Yes No

17. Has a claim been made against you by the owner of the goods? Yes No

If **Yes**, what is the amount of the claim AU\$_____ (*attach a copy of the claim/demands made against you*)

Do you require Associated Marine Insurers to:

- | | | |
|---|------------------------------|-----------------------------|
| 18. Pay the claim as a goodwill payment? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 19. Pay the claim because you believe you have a contractual obligation to do so? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 20. Pay the claim because you have already agreed to settle it? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 21. NOT pay the claim and defend the claim on your behalf? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 22. If No , do you expect such a claim to be made against you? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 23. Does the claim involve recoverable costs, which you have incurred? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 24. Has these invoices/accounts been paid by you? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
- (If **Yes**, please supply invoices and accounts to support your claim)

EFT PAYMENT DETAILS:

(Please only complete this section if you require payment directly into your account)

Account Name: _____

Account Number: _____

Bank Name: _____

BSB Number: _____

Bank Address: _____

Overseas Payment: _____ **Swift Code:** _____

ABA Code: _____ **Sort Code:** _____

Declaration

The answers given to questions in this claim form may require further information to be requested and/or further investigations to be made by Associated Marine Insurers or parties appointed by them. This may include contacting the owner of the goods or livestock to obtain documentation to verify the amount and extent of the claim.

I declare that to the best of my knowledge and belief the information in this form is true and correct and I have not withheld any relevant information.

I consent to Associated Marine Insurers Agents Pty Ltd using my personal information I have provided on this form for the purpose of processing my claim. I understand that if I choose not to provide the required details, this is my choice, however, Associated Marine Insurers Pty Ltd may not be able to process my claim.

I consent to Associated Marine Insurers Agents Pty Ltd disclosing my personal information to other insurers, an insurance reference service or as required by law. I consent to Associated Marine Insurers Agents Pty Ltd also disclosing my personal information to and/or collecting additional information about me, from investigators or legal advisors.

I understand that Insurers do not admit liability by the issue of this form.

Signature of Insured: _____ **Dated:** _____ **Position:** _____