LIABILITY CLAIM FORM

Tel: 011 803 7446 Fax: 011 807-6861

INSURER		POLICY NUMBER	VAT REG NUMBER
INSURED	Name & Occupation / Business		
	Address & Phone No.		
DESCRIPTION OF ACCIDENT OR DAMAGE	Date & Time		
	Place where accident/damage occurred		
	State exactly how the incident occurred		
WITNESSES	Name, address & Phone no.		
	Name, address & Phone no.		
POLICE	Police Station		
	Police Reference No.		
	Date Reported		
PROPERTY DAMAGE	Name & Address of Owner		
	Description of Damage		
PERSONAL INJURIES	Name, Address & Age of Injured Person		
	Details of Injuries		
	Name, Address & Age of Injured Person		
	Details of Injuries		
	Name, Address & Age of Injured Person		
	Details of Injuries		
RELATIONSHIP	If person named above is in your service, or your tenant, or related to you, give full details		
CLAIM	If claim made against you give details and attach any correspondence		
DECLARATION	I / We declare that to the best of my / our knowledge the above statements are truly made. Insured's Signature	Capacity	Date