CLAIM FORM

P.O. Box 14656, Farrarmere 1518,
U7 Lakefield Square, 106 Lakefield Avenue, Lakefield, Benoni 1501
Tel: 011 918 7240 • Fax: 011 918 7245

INSURED

Policy number:
Name:
Occupation:
Address:
Contact numbers: (w) (c)
(h) (f)
E-mail:

UNDERLYING POLICY

Underlying Insurer:
Underlying Policy Number:
Underlying Policy Premium:

Section	Amount Claimed	Section	Amount Claimed
Fire		Accidental damage	
Buildings combined		Public liability	
Office contents		Employers liability	
Business interruption		Stated benefits	
Accounts receivable		Group personal accident	
Theft section		Electronic equipment	
Money section			
Fidelity section			
Goods in transit			
Business all risks		**Total amount claimed**	

OCCURANCE

Date of Loss:
Description of loss:

In order for your claim to be processed, the following documentation must accompany this document:

- A copy of the premium summary of the Underlying Policy
- A copy of the relevant sections of the Underlying Policy
- Agreement of Loss from the Underlying Policy Insurer signed by both the Insurer and the Insured
- Any other documentation that may be requested

DECLARATION

I hereby declare the foregoing particulars to be true in every respect.

Signature of Insured _____ Capacity _____ Date _____