GEMINIA INSURANCE COMPANY LIMITED
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GEMINIA INSURANCE CO.LTD.

CARRIERS LIABILITY CLAIM FORM

INSTRUCTIONS:

- Please read carefully and fill out the entire form.
- All questions must be answered in full, in BLOCK letters, in the applicant's handwriting, or his dictation.

1. POLICY DETAILS

Policy Number_____ Policy Expiry Date_____

Date Of Loss / Accident_____

2.INSURED CONTACT DETAILS

Company Name / Insured Name_____

Street Address_____ Contact Name_____

Phone Number_____ Email Address_____

3.CLAIMANT DETAILS

Name of the person /company you carried goods for_____

Address of claimant_____ Contact phone number of claimant_____

4.TRANSIT DETAILS

Description Of Goods Being Shipped_____

Date Transit Commenced_____ Date Goods Delivered_____

Transit From (Address)_____ Transit To (Address)_____

How were the goods secured and protected on the carrying vehicle?_____

5.DETAILS OF LOSS

Has a claim been lodged against you? Yes☐ No☐

If yes, by whom_____

Who discovered the loss / damage?_____

Describe how the loss occurred_____

What actions were taken immediately after the loss?_____

6.DETAILS OF GOODS LOST / DAMAGED

Item	Nature of damage	Amount claimed

7.DOCUMENTS ATTACHED TO CLAIM REPORT (PLEASE TICK)

Police report	☐	Claim received against	☐	Your reply to claimant	☐
Commercial invoice	☐	Damage report	☐	Repair/replacement quote	☐
Sub-contractor agreement	☐	Consignment note (both sides)	☐	Contract terms	☐
Delivery docket	☐	Survey report	☐	Packing list / inventory	☐
Other	☐	(Please provide details)			

8.QUESTIONNAIRE / DECLARATION

Has any insurer refused orcanceled cover or imposed special terms for insurance?	Yes☐	No☐
Have you been charged or convicted of a criminal offence in the last 10 years?	Yes☐	No☐
Are there any other relevant facts relating to the risk or the claim that you should disclose to enable a true assessment?	Yes☐	No☐

If yes to any of the above please provide details:_____

_____

I/we declare all the above details are true in every respect to the best of my/our knowledge and belief.

Signature of insured_____

Name of insured_____

Date_____

Please indicate the number of additional pages attached to this claim form:_____