

GEMINIA INSURANCE COMPANY LIMITED

Head office: Le'Mac, 5th Floor
P.O. Box 61316-00200, Nairobi
Tel: 2782000 Fax: 2782100
Email: info@geminia.co.ke
www.geminia.co.ke



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

8.QUESTIONNAIRE / DECLARATION

Has any insurer refused or canceled cover or imposed special terms for insurance?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Have you been charged or convicted of a criminal offence in the last 10 years?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Are there any other relevant facts relating to the risk or the claim that you should disclose to enable a true assessment?	Yes <input type="checkbox"/>	No <input type="checkbox"/>

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: _____