



Registered FSP No 17607

## LIABILITY CLAIM FORM

<b>Insured</b>	<b>Name</b>		
	<b>Policy Number</b>		
	<b>E-mail Address</b>		
	<b>Contact Person</b>		
	<b>Contact Number</b>		
	<b>VAT Number</b>		
<b>Incident</b>	<b>Date and time of incident</b>	<b>Date:</b>	<b>Time:</b>
	<b>Place of loss</b>		
	<b>Estimate</b>		
	<b>Is this incident covered under any other policy of insurance?</b>	<b>Yes</b>	<b>No</b>
<b>Police</b>	<b>Place where reported</b>		
	<b>If reported – provide case number</b>		

<b>Witnesses</b>	<b>Name</b>	<b>1.</b>	<b>2.</b>
	<b>Telephone number</b>		

Property damage	<b>Name and address of owner</b>		
	<b>Description of loss or damage</b>		
Personal Injuries	<b>Name</b>	<b>1.</b>	<b>2.</b>
	<b>Address</b>		
	<b>Age</b>		
	<b>Telephone number</b>		
Relationship	<b>If any person named above is in your service, or your tenant, or related to you, give full details</b>		
Claims	<b>If a claim has been, or is being made against you, give details and attach any correspondence. *</b>		

Describe exactly how the incident occurred	

Declaration	<p>I / we declare that to the best of my / our knowledge the above statements are true.  I acknowledge that the information set out above is provided freely so that Centriq may process my claim and give effect to the terms and conditions contained in the policy wording. I herewith give my consent that Centriq may use this information, my personal information on record and additional information obtained from other sources in order to determine whether to accept or reject my claim, and take all necessary steps ancillary thereto to give effect hereto.</p>		
	<b>Insured's Signature</b>	<b>Capacity</b>	<b>Date</b>