

# General claim form



PERSONAL <input type="checkbox"/>	COMMERCIAL <input type="checkbox"/>	LOSS TYPE	
INSURANCE COMPANY		CLIENT NO IF KNOWN	
POLICY NO		EXCESS	DUE DATE

PURSUANT TO THE PRIVACY ACT 1993 THE FOLLOWING IS BROUGHT TO YOUR ATTENTION:

- |   |  |   |   |
|---|--|---|---|
| a | This claim form collects personal information about you          | d | The collection of this information is required pursuant to the terms of your insurance policy                       |
| b | The information is collected to evaluate your claim              | e | The failure to provide this information may result in your claim being declined                                     |
| c | The intended recipient of the information is:                    | f | You have rights of access to, and correction of, this information subject to the provisions of the Privacy Act 1993 |
|   | <div></div>  |   |   |
|   | herein after called ("the Company") and is being held by them at |   |   |

## 01 POLICY HOLDER

Full name of insured (Mr/Mrs/Miss/Ms)	Home telephone	Business telephone
Address	Mobile telephone	
	Email address	

## 02 CIRCUMSTANCES OF LOSS Please complete in all cases

Date	Day	Time
Where did loss occur?		
Is there any other insurance with any company relating to this loss?		
<input type="checkbox"/> Y	<input type="checkbox"/> N	If <b>yes</b> , please give details

If loss caused by another person, please give name and address

Have you, within the past five (5) years, made a claim against any Insurance Company?

☐ Y ☐ N If **yes**, please give details including co. name

Please explain what happened – continue on a separate sheet if necessary.

### 03 COMPLETE IN ALL CASES RELATING TO PROPERTY DAMAGE

Are you the sole owner of the property concerned?

☐ Y ☐ N

If **no**, please give details of other interest and party concerned

If burglary, loss, or theft claim, to which Police Station was it reported?

Date reported  Acknowledgement form attached ☐ Y ☐ N

If burglary, state means of entry to premises



NB: In the case of loss, please attach proof of ownership/purchase receipts and quotes for replacement cost to save delays.

DESCRIPTION OF PROPERTY LOST OR DAMAGED (STATE EACH ARTICLE/ITEM SEPARATELY)	DATE PURCHASED AND PRICE	PRESENT COST OF REPLACEMENT	AMOUNT CLAIMED

If more space is required, please complete on a separate page. Questions and Declaration on the back of this form must be completed.

TOTAL

If you are a tenant of a commercial building, please provide proof that you are liable under the terms of your lease.

DESCRIPTION (PLAIN, PLATE, ETC)	WHERE FIXED (WINDOWS, DOOR, ETC)

## Name of owner of property damaged

Address of owner of property damaged

Telephone number

Insurance Company (if known)

Was the owner known to you?

Y

☐ N

If **yes**, in what capacity?

Has a claim been made on you?

Y

☐ N

Description of damage

If you would like any payment due to be paid direct to a bank account, please provide account details:

Name of Account

BANK	

BRANCH

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ACCOUNT NUMBER

SUFFIX

**Note:** Failure to provide full and truthful information could result in the Claim being declined.

01 I/We agree to the Company disclosing my/our personal information regarding this claim to:

- a. other parties including other members of the Insurance Industry and the database of the Insurance Claims Register (ICR Ltd), PO BOX 474, Wellington, where it will be retained and made available to other insurance companies to inspect.
- b. parties who have a financial interest in the subject matter of the policy and parties repairing or replacing the subject matter of the claim.
- c. I/We understand that I am/we are entitled to have certain rights of access to and correction of the personal information held by the Company and ICR Ltd.

02 I/We agree to the Company obtaining personal information about me/us that is, in the Company's view, relevant to this claim.

- a. from any other party including other members of the Insurance Industry and from Insurance Claims Register ICR Ltd, which holds details of claims made by me/us under the policies with other insurers.

Insured's signature (If company, state capacity)

Date \_\_\_\_\_