

## FIRE INSURANCE CLAIM FORM

(Definite and complete answers must be given to each question. The issue or acceptance of this form to you or from you is neither to be regarded as an admission of liability nor as a waiver by the Company of any breach of the policy conditions.)

<b>THE POLICY</b>	Name of Insured:		Policy No:
	Address:		
<b>THE PROPERTY</b>	Location of Property destroyed/damaged:		
	Do you have sole interest in the affected Property? YES <input type="checkbox"/> NO <input type="checkbox"/> If not, provide details of other interests (i.e. lessors, mortgagees etc.):		
	How were premises occupied at date of fire?		
	Does policy give a correct description of the property in all respects as it existed immediately before the fire?		
	Has there been any alteration in the occupation or use of the property since the policy was taken out?		
	Are there other insurances in force on the Property? YES <input type="checkbox"/> NO <input type="checkbox"/> If any, give details of:		
	Company	Policy No	Amount Insured
	1.		
	2.		
	3.		
What was the sound value of all the property covered under the above-mentioned policy immediately before the loss?			
Building:		Stock-in-trade:	
Other Contents (describe) :			
<b>THE CAUSE</b>	Date and Hour of Fire or Cause:		
	Estimated amount of loss:		
	Describe in detail how it occurred: <span style="float: right;"><i>(Use a supplementary sheet if necessary)</i></span>		
	Give brief details of any previous loss of a similar nature or fire in which you were interested:		

I/We do hereby declare the foregoing particulars including those overleaf and the attached documents submitted in support of my/our claim to be true in every respect and I/We further declare that the property worth \_\_\_\_\_ as described overleaf was accidentally destroyed or damaged by the aforesaid cause without any design or procurement on my/our part. I/We claim and agree to accept from \_\_\_\_\_ (the insurers) the amount of \_\_\_\_\_ in full satisfaction of my/our claim under the aforesaid policy.

Signature of Insured/Claimant (Company's Stamp)

Date: \_\_\_\_\_

