



PUBLIC LIABILITY CLAIM FORM

Insured	Policy Number		
	Name		
	Identity No.		
	Occupation		
	Address / Tel		
	Contact person		
Details of Accident	Date	Time	Date Reported to you.
	Place of Accident		
	Police Station	Date Reported on	Policy Reference No.
	Describe in detail how the accident occurred (If possible, attach a sketch plan)		
	Relationship of Claimant to the Insured		
Claimant	Name		
	Identity No.	Occupation	
	Address / Tel		
Injuries or Damage	Full details of personal injuries or damage		
	Has any claim been lodged against you?		If yes, state amount
	Has the claimant made any offer or suggestion to settle the claim?		
	WITNESS DETAILS		
	Name		
	Address		
	Tel Number		
	Name		
Address			
Tel Number			
To your knowledge, has any other accident occurred at the same place under similar circumstances?			
Was the accident attributed to lack of ordinary caution on the part of the claimant?			
If yes, in what respect?			
Declaration	I / We hereby declare the foregoing particulars to be true in every respect and that no information has been withheld.		
	Signature of Insured _____ Capacity _____ Date _____		