



PUBLIC LIABILITY CLAIM FORM

NOTE: (1) The Issuance of this Form does not imply admission of Liability
(2)The Insured is required to answer all questions fully and return without delay.

POLICY NO.....CLAIM NO.....

BRANCH OR AGENT.....

NAME OF INSUREDõ ..

ADDRESSõ .

õ õ

õ TEL. NOõ õ õ õ õ õ õ õ õ õ õ õ õ

TRADE OR OCCUPATION (If more than one state all)õ õ õ õ õ õ õ õ õ õ õ õ õ õ õ .

Date of Accidentõ õ õ õ õ õ õ õ õ õ õ õ ..Timeõ õ õ õ õ õ õ õ õ .a.m/p.m

Placeõ õ

Explain fully how accident occurredõ õ

õ ..

õ ..

õ ..

õ ..

When was the accident reported to you?õ õ õ õ õ õ õ õ õ õ õ õ õ õ õ õ õ õ

By whom?õ õ

Did the accident arise from the activities of persons in your direct employ?õ õ õ õ õ ..

If so give names and addresses of employeesõ õ õ õ õ õ õ õ õ õ õ õ õ õ õ õ õ õ ..

õ ..

õ ..

Names and addresses of any other witnessõ õ õ õ õ õ õ õ õ õ õ õ õ õ õ õ õ õ

õ õ

õ .

