

BUILDINGS CLAIM FORM			
INSURER		BROKER	
POLICY NUMBER		BROKER CONTACT DETAIL	
INSURED	NAME	INSURED CONTACT :	
	BUILDING OCCUPIED AS	INSURED TEL / CEL NR.	
	PHYSICAL ADDRESS	INSURED EMAIL :	
LOSS DETAIL	Date of Loss :	Time of Loss :	
	When was loss discovered ?		
	Was buildings occupied at the time of Loss ?		
	If not occupied, when was building last occupied ?		
	Type of Roof - Pitched / Flat		
Construction (Material Type) - Iron / Asbestos / Slate / Tile / Concrete / Thatch / Other(Specify)			
DESCRIPTOIN OF CLAIM / LOSS / DAMAGE.	Please described fully how the Loss and / or Damage occurred. If applicable please state how entry/exit was gained into/from the premises / buildings.		
	Please state exactly which part/s of the building / property were damaged. (ie. Items / rooms / floors / roof / walls / ceiling etc.)		
If loss / damage was caused by another party please supply Name, Address and Contact Details of that party and if applicable Vehicle Registration Number .		Vehicle Registration Nr.	
PREVIOUS LOSS / DAMAGE HISTORY	Have you previously suffered a loss ?		
	If YES, please provide details thereof :		
	If Insured, provide Details :		
POLICE DETAILS (If Applicable)	Date Reported	Has any other party an interest in the Insured Property ?	
	Case Number	Name of Party	
	Police Station	Bond / Loan Acc Nr.	
OTHER INSURANCE	Is there any other Insurance policy covering this Loss / Damage ?		
	If YES, please provide Name of Insurer & Policy Number.		
VALUE AT RISK	Estimated Replacement / Rebuilding Costs of Buildings.		
	When was this last valued ? Or the value thereof reviewed ?		
DECLARATION			
I / We solemnly declare that I / We have suffered loss of or damage to the property as detailed herein. I /We further declare that the particulars supplied above are true in all respects. I / We hereby waive any right to privacy in any claims information supplied by me/us or on my behalf and consent to such information being disclosed to any other insurance company or its agent. I / We further waive aby rights of privacy and consent to the disclosure of any information relevant to any insurance claim concerning me/us or any insured person/s I/We represent.			
Insured Signature		Date (YYYY / MM / DD )	
Capacity			