



CLAIMS ADVICE

CLIENT CODE: _____

FULL NAME OF INSURED: _____

Details & Location of Loss _____

Date of Loss _____

Contact Name _____ Phone No: _____

Fax Number _____ E-mail _____

Class of Insurance: _____ Policy No: _____

Insurer: _____ Expiry: _____ Excess: \$ _____

Details of Loss or Damage _____

Estimate of loss: \$ _____

For Motor only

Make/Model: _____ **Reg. No:** _____

Details of Loss or Damage _____

For Workers Compensation only:

Employees Name: _____

Type of Injury: _____

Signed: _____ Date: _____

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