

Please complete all questions as fully as possible, using space provided as well as additional pages as required. Once complete please sign and email claims@4sightrisk.com.au

THE INSURED

Name of Insured:						
Tax Status:	A.B.N.	ITC Percen	C Percentage of Premium for this Policy Section: %			
Policy Number:						
Postal Address:					Postcode:	
Contact Name:		1	Telephone:			
Mobile:			Email:			
INCIDENT DETAILS						
Date of Incident: D D M M Y Y Time: : AM PM						

DETAILS OF DAMAGE ITEM(S)

DETAILO OT L		
Туре:	Make:	
Model:	Serial No:	

Please state fully the circumstances of the event which has given rise to this claim.



REPAIRS Have Repairs Commenced?	YES NO	Invoiced/E	stimated Cost \$)		Please attach invoice	s if repairs complete
Name of Repair Company:							
Contact Name:					Telephone:		
Mobile:					Email:		
Please supply ban	< details for settle	ement	ACCOUNT NA	ME	BSB	ACCOUNT NUMBER	REFERENCE

I hereby warrant the truth of the foregoing statements and the particular of the above items and I make the solemn declaration conscientiously believing the same to be true.

Signature:	Date:	
	-	

THE ISSUE AND/OR ACCEPTANCE OF THIS FORM IS NOT IN ITSELF AN ADMISSION OF LIABILITY ON THE PART OF 4SIGHT RISK PARTNERS.

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