



A.B.N. 17 000 434 720

# CARGO/GOODS IN TRANSIT CLAIM FORM

## THE INSURED

Full Name		Contact Details	Private:
Address			Business:
	Postcode		Mobile:
What is your Occupation, Trade or Profession? (including Part-Time)			Email:

## POLICY DETAILS

Policy Number	Policy Expiry Date
---------------	--------------------

## GOODS AND SERVICES TAX

To ensure you do not incur any unnecessary GST liabilities on this claim please complete these details.

Are you registered for GST purposes? No  Yes

What is your ABN?

If you have an ABN, have you claimed or will you be claiming an input tax credit on the GST applicable to this policy? No  Yes

Are you entitled to an Input Tax Credit for the goods which is subject to this claim? No  Yes  Please Specify  %

Is the amount claimed less than 100% of the GST applicable to the premium? No  Yes  Please Specify  %

Please note that this information is used by the insurer for their own GST calculations and will not affect your claim.

## THE GOODS

Are you the owner of the lost/damaged goods? Yes  No

If 'No', please provide details of the owner

Describe the goods

If the goods are damaged, where can they be inspected?

CONTACT Name:  Phone No.:

Police must be notified of any stolen goods.

Police Station  Report No.  Date  /  /

## THE TRANSIT

Please provide details of the transit

Carrier's Name:

Journey From  To  Date  /  /

Type of Transport

Road Carrier  Sea  Post

Own Vehicle  Air  Rail



Additional Information you may wish to provide should be set out below.

A large rectangular area containing numerous horizontal dotted lines, intended for providing additional information.