Insurance Company Limited, P. O. Box 782 – Accra
Tel: 233964 / 229807/ Fax: 233 21 239463

GOODS – IN- TRANSIT CLAIM FORM

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1. Name of Insured:………………………………………………………….Policy No…………………………………
   Address:……….
   Business:……..

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2. Date, Hour and place of accident:……………………………………………………………………………
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3. Cause (Full information):……………………………………………………………………………………….
   ……..
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4. Nature and extend of Loss:……………………………………………………………………………………
   ……..
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5. (a) Registration No. of Vehicle involved:…………………………………………………………………….
   (b) The owner of vehicle:……………………………………………………………………………………….

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6. Has the Accident been reported to the Police?..

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7. Give the number/name of the Policeman, if any who took particulars:
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8. Name and address of witness of the accident:…………………………………………………………….
   ……..
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I/We hereby declare that to the best of my/our knowledge and belief, the above statements are fully and truly made.

Date:…………………………. ………………………………………..
Insured’s Signature