THE INSURANCE COMPANY OF THE WEST INDIES LIMITED

2 St. Lucia Avenue, Kingston 5, Tel: 926-9040-7, 926-9182-91, Fax: 929-6641

PUBLIC LIABILITY INSURANCE CLAIM FORM

(The Company does not admit liability by the Issue of this form)

I hereby declare that all particulars to be given are true and correct and that no false or fraudulent statement will be made _____
Insured's Signature

NOTE: "N/A" means "Not Applicable"

Policy No.	Source	Client No.
Claim No.	Date of payment of last premium	

Name of Insured _____

Address _____

Business or Occupation _____

Email Address _____

Date of Accident _____ Time _____

Where did the accident occur? _____

Cause of Accident and the circumstances under which it arose _____

Names and Addresses of Witnesses (1) _____

(2) _____

Names and Addresses of persons injured or whose property was damaged

(1) _____

(2) _____

Full details of injuries or damage sustained:

(a) Bodily injuries _____

(b) Damage of Property _____

I HEREBY DECLARE THAT THE ABOVE IS A FULL, TRUE AND ACCURATE STATEMENT.

Insured's Signature _____ Date _____