

**Bryte Insurance Company Limited**

A Fairfax Company

Registration number: 1965/006764/06 VAT number: 4530103581

Authorised Financial Services Provider No. 17703

15 Marshall Street, Ferreirasdorp, Johannesburg, 2001 PO Box 61489, Marshalltown 2107

Please complete this form in BLOCK CAPITALS and send it to your broker or to Bryte Insurance Company Limited.

INSURED		BROKER	
ADDRESS		POLICY NUMBER	
		TELEPHONE NUMBER	
		EMAIL ADDRESS	
		INSURED'S VAT NUMBER	
BUSINESS OR OCCUPATION			
DESCRIPTION OF GOODS BEING TRANSPORTED AT THE TIME OF THE INCIDENT			
LOAD VALUE	R	TOTAL WEIGHT	
NUMBER OF PACKAGES		HOW WERE THE GOODS PACKED?	
REGISTRATION NUMBERS OF YOUR VEHICLE/S CONCERNED			
ADDRESS FROM WHICH GOODS WERE DESPACHED			
	DATE DESPACHED		
WERE YOU THE	<input type="checkbox"/> PRINCIPAL CONTRACTOR , OR A <input type="checkbox"/> SUB-CONTRACTOR		
WAS THE DELIVERY	I) <input type="checkbox"/> TO A THIRD PARTY    II) <input type="checkbox"/> TO A CUSTOMER    III) <input type="checkbox"/> AN INTER-BRANCH CONSIGNMENT		
<b>CIRCUMSTANCES OF LOSS OR DAMAGE AND PARTICULARS OF GOODS LOST OR DAMAGED</b> <i>NOTE: ALL INVOICES, DELIVERY NOTES, RECEIPTS AND CORRESPONDENCE ARE TO BE SENT WITH THIS FORM</i>			
DATE OF LOSS OR DAMAGE		TIME	<input type="checkbox"/> AM <input type="checkbox"/> PM
PLEASE PROVIDE A BRIEF DESCRIPTION OF THE INCIDENT			
IF ANOTHER VEHICLE WAS INVOLVED, PLEASE STATE NAME AND ADDRESS OF OWNER AND THEIR INSURERS (IF KNOWN)	OWNER	INSURERS	

WERE THERE ANY WITNESSES		<input type="checkbox"/> Yes <input type="checkbox"/> No		IF YES, PLEASE PROVIDE THE FOLLOWING DETAILS BELOW:	
NAME:					
PHYSICAL ADDRESS:					
TELEPHONE NUMBER:		(                    )			
EMAIL ADDRESS					
IF YOUR VEHICLE WAS UNATTENDED WHEN LOSS OR DAMAGE OCCURRED, HOW WAS IT SECURED?					
WERE THE GOODS IN SOUND CONDITION WHEN RECEIVED?				<input type="checkbox"/> Yes <input type="checkbox"/> No	
WERE THEY CHECKED BY YOUR DRIVER?				<input type="checkbox"/> Yes <input type="checkbox"/> No	
DID THE CONSIGNEE ACCEPT DELIVERY?				<input type="checkbox"/> Yes <input type="checkbox"/> No	
IF SO, WAS A RECEIPT GIVEN?				<input type="checkbox"/> Yes <input type="checkbox"/> No	
DO YOU USE THE STANDARD TRADING CONDITIONS OF CARRIAGE?				<input type="checkbox"/> Yes <input type="checkbox"/> No	
IF NOT, WHAT CONDITIONS OF CARRIAGE DO YOU USE?					
(PLEASE ATTACH A SPECIMEN COPY)					
HAS A CLAIM BEEN MADE AGAINST YOU BY THE OWNER?			<input type="checkbox"/> Yes <input type="checkbox"/> No		DATE RECEIVED
WAS THE MATTER REPORTED TO THE POLICE?			<input type="checkbox"/> Yes <input type="checkbox"/> No		DATE ADVISED
POLICE STATION					
POLICEMAN'S NAME					
IF THEFT/HIJACK, WAS THE MATTER REPORTED TO RECOVERY AGENTS?			<input type="checkbox"/> Yes <input type="checkbox"/> No		DATE ADVISED
DETAILS OF BRANCH/CONTACT					
QUANTITY	DESCRIPTION			VALUE	
				TOTAL	
ADDRESS WHERE DAMAGED GOODS CAN BE INSPECTED					

## DECLARATION

I/We acknowledge the sharing of claims information by insurers is essential to enable the insurance industry to underwrite policies and assess risks fairly and to reduce the incidence of fraudulent claims. In the public interest and with a view to limiting premiums, I/We hereby waive any right to privacy in any insurance or claims information supplied by me or on my behalf in respect of any insurance application or claim made or lodged by me/us and I/we consent to such information being disclosed to any other insurance company or its agent. I/We also waive any rights to privacy and consent to the disclosure of any information relevant to any insurance claim concerning me or any insured person I/we represent.

I/We further declare that all the particulars to be true in every respect and correct and I/We understand that if any claim lodged under this policy be in any respect fraudulent or if any fraudulent means or devices be used by me/us or anyone acting on my/our behalf or with my/our knowledge or consent to obtain any benefit under this policy or if any event be occasioned by the wilful act or with the connivance of me/us, the benefit afforded under this policy in respect of such claim shall be forfeited.

SIGNATURE OF INSURED \_\_\_\_\_ CAPACITY \_\_\_\_\_ DATE \_\_\_\_\_