



Machinery Claim

The issue of this form does not constitute an admission of liability on the part of the insurer.

All original repair/replacement invoices/work sheets MUST be submitted to us with this claim as soon as practical.

Policy Number

Claim Number

Please complete all sections

THE INSURED

Full Name (Block Letters)	Surname	Given Name(s)											
Postal Address													
										State	Postcode		
Are you registered for GST?	No <input type="checkbox"/>	Yes <input type="checkbox"/>	What is your ABN?	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	
Have you claimed or intend to claim an input tax credit on the GST component of the premium applicable to the Policy?	No <input type="checkbox"/>	Yes <input type="checkbox"/>	- Will you be claiming an amount less than 100%?										
	No <input type="checkbox"/>	Yes <input type="checkbox"/>	- Specify amount claimed							<input type="text"/>	%	<input type="text"/>	
Are you entitled to claim an input tax credit for repairs or replacement of the item that has been lost or damaged?	No <input type="checkbox"/>	Yes <input type="checkbox"/>	- Will you be claiming an amount less than 100%?										
	No <input type="checkbox"/>	Yes <input type="checkbox"/>	- Specify amount claimed							<input type="text"/>	%	<input type="text"/>	
Contact Numbers	Business	(<input type="text"/>)	Private	(<input type="text"/>)					
	Facsimile	(<input type="text"/>)	Mobile	<input type="text"/>							
Location of Equipment	<input type="text"/>												
Are there any other insurances in force which would cover this loss in whole or in part?											No <input type="checkbox"/>	Yes <input type="checkbox"/>	- give details
Name of Insurer	<input type="text"/>							Policy Number	<input type="text"/>				

INCIDENT DETAILS

Day and Date of Incident	<input type="text"/>	/	<input type="text"/>	/	<input type="text"/>
Description of Item	<input type="text"/>				
<input type="text"/>					
<input type="text"/>					
Details of Item					
Make	<input type="text"/>	Type	<input type="text"/>	Model	<input type="text"/>
Serial No.	<input type="text"/>	Year of Manufacture	<input type="text"/>	HP/KW	<input type="text"/>
What happened?	<input type="text"/>				
<input type="text"/>					
<input type="text"/>					
<input type="text"/>					
<input type="text"/>					

