Name on Bill of Lading_____

PRESENTATION OF CLAIM FOR LOSS AND DAMAGE

Use this form for Local or Intrastate Claims

DATE CLAIM RECEIVED:	
ADJUSTER:	
NUMBER:	

INSTRUCTIONS TO CLAIMANT

The carrier is required to process your claim if this completed form is received by the carrier within 30 days of the delivery date for the move. The carrier will not be responsible for a claim unless the claim is forwarded to and received by the carrier.

In order to expedite the claim process, the following procedures should be followed.

1. Check and/or complete the heading information.
2. List the name of the article claimed and description of damage. If available, list the inventory number, the article's age, the original cost, and the current replacement value.
3. Sign and date the claim form. Make a copy for your records.
4. Mail the completed claim form to the carrier.
5. Do not discard any claimed item or attempt to have a damaged item repaired prior to the carrier's inspection.

If you should have any questions or need further assistance, please call your carrier and ask for the Claims Department.

DETAILS OF CLAIM

ORDER NUMBER	DATE LOADED	DATE DELIVERED	FROM (CITY, STATE)	TO (CITY, STATE)

THE COMPANY RESERVES THE RIGHT TO REQUIRE NOTARIZED STATEMENT OR AFFIDAVIT.

If moved previously, give Name of Carrier _____ Order No. _____ Date _____

Origin _____ Destination _____

INVENT. NO.	ARTICLE	State If Loss or Damage If Damage – Describe Extent	Estimated Weight	Date Acquired	Original Cost	Present Value	Amount Claimed	Estimated Cost Of Repair	Home Office Use Only

Were exceptions noted on inventory at destination? Yes ☐ No ☐ Total:

I am the owner of the property described. I did not cause or contribute to the damage set forth herein.

All statements made in this statement of claim and any attached documents are true and correct to the best of my knowledge and belief, and constitute my complete and entire claim. No material information has been withheld.

SHIPMENT RELEASED AT:

_____ VALUATION DECLARED ON B/L $_____

SIGNATURE OF CLAIMANT DATE

_____

CLAIMANT'S FULL ADDRESS (STREET, CITY, STATE, ZIP) HOME PHONE # BUSINESS PHONE #

INSPECTOR'S REMARKS

INSPECTOR: LIST BELOW A FULL REPORT OF YOUR OBSERVATIONS, CONCLUSIONS AND RECOMMENDATIONS WITH RESPECT TO EACH ITEM LISTED ABOVE.

_____

_____

_____

Claim reported by _____ and Inspected by _____ Date _____

Code Agent