

Insurance Claim Form

Body Corporate / Strata Insurance Policy

Insured Details

Name of Insured: _____ CTS No: _____

Property Address: _____

Suburb: _____ State: _____ Post Code: _____

Policy Number: _____ Policy Expiry Date: _____

Insurer: _____

Broker name: _____

Insured's ABN: _____

Registered for GST: Yes No Percentage of GST claimable (ITC): _____%

Property Details

Details of where the loss/damage occurred

Lot/Unit Number: _____

Street Address: _____

Suburb: _____ State: _____ Post Code: _____

Are the premises currently tenanted? Yes No

Was the premises tenanted at the time loss/damage occurred? Yes No

Details of Property Manager:

Name: _____ Company: _____ Phone: _____

Details for access if internal unit inspection required by Assessor:

Name: _____ Phone: _____

Details for Loss of Rent

Complete this section for Loss of Rent Claims only

Is there any loss of rent pertaining to this claim? Yes No

Rent per week: \$_____ Period untenanted due to loss/damage: _____ weeks

Have you provided documents to support the above? Yes No

Details of Loss/Damage

Date of Loss: _____ Time of Loss: _____ am/pm

Details of loss/damage and how it occurred:

Details of items being claimed

| <i>Description of Item</i> | <i>Replacement/Repair Cost</i> | <i>Amount Claimed</i> |
|----------------------------|--------------------------------|-----------------------|
| | \$ | \$ |
| | \$ | \$ |
| | \$ | \$ |
| | \$ | \$ |
| | Total Claimed: | \$ |

Additional Details

Is anyone responsible for the loss/damage? Yes No

If yes, details of person/party responsible:

Name: _____ Phone: _____

Address: _____

Other details: _____

Were there any witnesses to the loss/damage? Yes No

If yes, details of witness:

Name: _____ Phone: _____

Address: _____

Was the incident reported to Police? Yes No

Date Reported: _____ Station reported to: _____

Police Crime Report Number: _____

Declaration

I/we declare that the information given in this form is truthful, accurate and complete. No information likely to affect this claim has been withheld. I/we understand that this claim may be refused if information is untrue, inaccurate or concealed.

Signature: _____

Name: _____

Date: _____

Please forward this completed claim form and supporting documents to:

Tcmstrata
PO Box 5332
CAIRNS QLD 4870
Email: info@tcmstrata.com
Phone: (07) 4031 7877
Fax: (07) 4031 5762