



REGENCYNEM INSURANCE GHANA LIMITED

P.O. BOX CT 6342, Cantonments, ACCRA
TEL. (233-302) 778106/768463/769789 FAX: 233-302-782871

PLANT AND MACHINERY CLAIM FORM

POLICY NUMBER:.....

1. (a) Name and Address of Insured
-
-
- (b) Address of Plant:.....
-
- (c) Name of Chief Engineer or Plant Manager:.....
-

2. (a) When did the loss or damage occur? At.....**a.m** / **p.m**, on.....
- (b) When was notice first given to the Insurer:
- (i) To Whom:.....
- (ii) By Whom:.....
-

3. Are there any witness?....., If so, please give Names, Professions and Addresses below:
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-
-
-

4. (a) Which Item (s) was / were damaged?.....
- (b) Item Number in specification
of Policy Schedule
- (c) Sum Insured
- (e) Type of Machine
- (f) Year of Manufacture, serial No.
- (Please give full details as on
Manufacturer's plate)
- (g) Description of damaged item(s)
- (Capacity, rpm, weight, etc)
- (h) Had the manufacturer's Yes No
Guarantee period for the
Damaged item expired? If so, when?
-

5. Which parts were damaged?.....
.....
.....

6. How did the damage occur, and what was its probable cause (Please attach sketches, photos etc.)
.....
.....
.....

7. Do the fractures show any sign of faulty casting, faulty material or previous repair?
If so, please give details:.....
.....

8. Are any alterations or improvements of design, construction or material being effected whilst repairs are being made?.....
If so, please give details:.....

9. (a) How will the damaged items be repaired, by *whom* and *where*?.....
.....
.....
(b)Please indicate approximate repair period:.....

10. What is the Total Estimated Repair amount?.....

11. Was any third party or surrounding property damaged?.....
If so, please give details:.....
.....

12. Remarks:.....
.....
.....

Please enclose copy (ies) of repair estimate(s), which should show a breakdown into material costs, labour charges – including man-hours worked and freight charges.

I / We hereby declare that to the best of my / our knowledge and belief, the above statements are fully and truly made.

Insured's Signature:.....

Date:.....