Claims notification form

Liability insurance

Note

Please send the completed and signed claims notification form to:

KESSLER & CO Inc.

Forchstrasse 95

P.O. Box
CH-8032 Zurich

T +41 44 387 87 11

# Policy number

Policyholder

|  |  |
| --- | --- |
| Name, first name / company |       |
| Contact person |       |
| Street, postal code, place |       |
| Phone, mobile, fax |                   |
| E-Mail |       |
| Bank details for claims payment |
| Name and address of bank |       |
| Account number, Clearing number |             |
| IBAN, BIC |             |
| Postal account |       |
| Account holders |       |
| Can you recover de VAT? [ ]  Yes [ ]  No |

Description of the claim

|  |  |
| --- | --- |
| Date and time |       |
| Street, postal code, place |       |
| Phone, mobile, fax |                   |
| E-mail |       |
| Has a statement of facts been officially taken? [ ]  Yes [ ]  No |
| Course of events(please also fill in, if a police report has been issued and attach reports, drafts or pictures)      |

Who caused the loss?

|  |  |
| --- | --- |
| Name, first name |       |
| Street, postal code, place |       |
| Phone, mobile, fax |                   |
| E-mail |       |
| Is this person a relative of the policyholder? [ ]  Yes [ ]  No |
| If Yes: | * Degree of relationship
 |       |
| Is this person employed by the policyholder? [ ]  Yes [ ]  No |
| If Yes: | * Position
 |       |

Cause of loss

What / who has caused the loss?

|  |
| --- |
| Has the loss been caused by your fault of by the fault of a family member or by an employee? [ ]  Yes [ ]  No |
| If Yes | * Cause
 |       |
| Faulty / deficient material and / or installation? [ ]  Yes [ ]  No |
| If Yes: | * Cause
 |       |
| Has the loss been caused through the fault or partial fault of the claimant and / or a third party? [ ]  Yes [ ]  No |
| If Yes: | * Cause
 |       |
|  | * Name, first name
 |       |
|  | * Address, postal code / Place
 |       |

Witnesses

|  |  |
| --- | --- |
| Name, first name |       |
| Street, postal code, place |       |
| Phone, mobile, fax |                   |
| E-mail |       |

Details / data of injured or dead persons

|  |
| --- |
| Where there any injured or dead persons? [ ]  Yes [ ]  No |
| If Yes: | * Description of injury
 |       |
|  | * Name of the doctor / hospital
 |       |
| Name, first name |       |
| Street, postal code, place |       |
| Phone, mobile, fax |                   |
| Date of birth |       |
| Employer |       |

Damages or destruction of third party property / animals

|  |
| --- |
| Has any third party property been damaged or destroyed? [ ]  Yes [ ]  No |
| If Yes: | * What
 |       |
|  | * Age
 |       |
|  | * Description of damages
 |       |
|  | * Name, first name of the owner
 |       |
|  | * Street, postal code, place
 |       |
|  | * Location of inspection
 |       |
|  | * Estimated amount of loss
 |       |

Additional questions

|  |
| --- |
| Is the claimant employed or appointed by you? [ ]  Yes [ ]  No |
| If Yes | * In which position / function?
 |       |
| Has the incident occurred during work forming part of a joint-venture? [ ]  Yes [ ]  No |
| If Yes: | * Name of the Consortium
 |       |
| Have the claims for compensation already been filed? [ ]  Yes [ ]  No |
| If Yes: | * Amount claimed
 | CHF       |

Additional comments

Consent

The undersigned authorizes the insurance company to obtain any information regarding the claim from other insureds or third parties and to examine any official and court documents which are related to the claim. Furthermore, the insurance company has the right to remit data to official or legal institutions and to any other insurance companies (co-insurers or reinsurers) in Switzerland and abroad which are involved in the claim. The undersigned is asked to refrain from accepting any claims without prior consultation with the insurance company.

|  |
| --- |
| Place and date |

|  |
| --- |
| Signature / stamp of the policyholder |