

STANDARD FORM FOR PRESENTATION OF LOSS AND DAMAGE CLAIM

TO: _____

DATE

CLAIMANT NUMBER

CARRIERS PRO NUMBER

THIS CLAIM FOR \$ _____ IS MADE AGAINST YOUR COMPANY FOR LOSS(ES) DAMAGE(S) IN CONNECTION WITH THE FOLLOWING SHIPMENT

Shipper Name	Consignee Name
Shipper Address	Consignee Address
City / State / ZIP	City / State / ZIP

IF SHIPMENT WAS RECONSIGNED EN ROUTE, STATE PARTICULARS: _____

DETAILED STATEMENT SHOWING HOW AMOUNT OF CLAIM IS DETERMINED

Description of Claim <small>(PLEASE GIVE ITEM NUMBER, COMMODITY DESCRIPTION, NUMBER OF PIECES CLAIMED, AMOUNT BEING CLAIMED. ALL DISCOUNTS AND ALLOWANCES MUST BE SHOWN)</small>	Amount(s)

NMFC Item No.: _____ Total Amount of Claim: _____

- | | |
|---|--|
| <input type="checkbox"/> Original Bill of Lading
<input type="checkbox"/> Original invoice or certified copy
<input type="checkbox"/> Consignee concealed loss or damage form
<input type="checkbox"/> Carrier's Inspection Report Form (Concealed loss or damage) | <input type="checkbox"/> Original paid freight bill or other carrier document bearing notation of loss or damage if not shown on freight bill
<input type="checkbox"/> Shipper's concealed loss or damage form
<input type="checkbox"/> Other particulars obtainable in proof of loss or damage claimed (list below) |
|---|--|

(NOTE: The absence of any documents called for in connection with this claim must be explained. When impossible for claimants to produce original bill of lading or paid freight bill, a bond of indemnity must be given to protect carrier against duplicate claim supported by original documents.)

INDEMNITY AGREEMENT

In the absence of the Original Freight Bill and/or Original Bill Of Lading, we agree to hold the above named carrier to whom this claim is presented and any other participating carrier, harmless and indemnified against any and all lawful claims which may be made against it or them arising out of the same shipment and will pay to the said carrier and any participating carriers(s), all losses, damages, costs, counsel fees or any other expenses which they or any of them may suffer or pay by reason of payment of our claim, herein described, without the surrender of the original Freight Bill or Bill Of Lading, as such was not provided and/or cannot be located.

Note: If the section below is not filled out completely, it is very possible that your claim WILL NOT be processed.

The foregoing statement of facts is hereby certified as correct.

PERSON FILLING OUT THE CLAIM FORM	COMPANY NAME
CLAIMANT SIGNATURE AND TITLE	COMPANY ADDRESS
TODAYS DATE	PHONE NUMBER / FAX NUMBER
E-MAIL ADDRESS	