



ក្រុមហ៊ុនធានារ៉ាប់រង កម្ពុជានិយម

CAMPU LONPAC INSURANCE 柬埔寨大众伦平保险

No:

WINDSCREEN CLAIM FORM

For Office Use Only	Date :
Policy No.	
Vehicle No.	
Signature	

"IT IS IMPORTANT that this form is completed fully and returned to the company within 14 days. Send all communications you may receive to us immediately. You are also not to admit that your driver was at fault, or that you are liable for the accident."

SECTION A POLICYHOLDER

1. Name :

2. Address (Office) :

Telephone No.(Office) : -

3. Address (House) :

Telephone No.(Home) : - Hand Phone No : -

4. Business/Occupation :

5. Windscreen Coverage : _____

SECTION B DRIVER OR PERSON IN CHARGE OF INSURED VEHICLE

1. Name :

2. Address (Office) :

3. Telephone No.(Office) : -

4. Address (House) :

5. Telephone No.(Home) : -

6. Driver's Occupation :

7. Age on date of incident : Year(s)

8. Driving experience : Year(s)

SECTION C PARTICULARS OF VEHICLE

- 1. Make and model : _____
- 2. Registration No. : _____ Capacity : _____ cc
- 3. Year of make and colour : _____

SECTION D OCCURRENCE

- 1. Date : _____ Time : _____ am / pm
- 2. Location of incident : _____
- 3. Name and address of nearest : _____
repairer

I declare that these answers and statements are true and correct In accordance with the Policy Conditions, I will forward immediately any correspondence relating to the occurrence.

Signature Of Driver :

Date :

Signature Of Insured :

Date :