

Claim Form to GCM GmbH

Ringstrasse 9-11, 50996 Cologne
Telephone +49 221/34 809-60, Fax +49 221/93 54 682
gcm@gielisch.de



Name of Insured

Last name		First name	
Street		Postcode/Place	
Telephone	Fax	E-Mail	

Name of Insurer

Name of Contact Person

Telephone	Fax	E-Mail
-----------	-----	--------

Type of Coverage

Insurance Policy No.

Loss Location	Date	Time
---------------	------	------

Circumstances of Loss

Reporting Police Station

Officer's Name

Telephone	Log No.
-----------	---------

Were charges filed or was a fine imposed

If so, against which party?

Company	Name
Street	Postcode/Place

Loss/Damage involved personal injury property loss/damage, other loss/damage
rough estimate of total amount of loss

Responsible party, injured party, other parties concerned (including witnesses)

Name	Type of involvement
Street/Place	Telephone
Name	Type of involvement
Street/Place	Telephone
Name	Type of involvement
Street/Place	Telephone

Notes

Insured's Duty of Disclosure

The Insured and the injured person are obliged to provide true and complete information to the Insurer. The Insurer shall be discharged from obligation to pay a claim if incomplete or untrue information is provided by the Insured or the injured person out of intent, gross negligence or wilful deceit. Where incorrect information is provided deliberately, the same legal consequence shall apply, even if such information does not affect the amount or scope of compensation payable by the Insurer.

Date

Signature

(by proxy of Insured)