



# Ocean Glass and Glazing

Your Reliable Local Glazier

Telephone: (08) 9510 9963

Mobile: 0400 612 499 (24/7)

Email: info@oceanglass.com.au

## INSURANCE CLAIM DETAILS

### FOR YOUR INFORMATION:

Upon the return of a fully completed claim form, our invoice will be posted or emailed to your nominated Insurance Company along with a copy of this form. A copy of our invoice will also be faxed or emailed to the Policy holder below for a reference should you receive payment direct from your insurance company.

### PLEASE NOTE:

**Ocean Glass must have your claim details no longer than 3 (three) days after the date of loss to process your claim efficiently.** With no instructions or contact received within 3 (three) days Ocean Glass will issue an invoice direct to the work site and the full costs for the repairs will be due PAYABLE DIRECT TO OCEAN GLASS as per our trading terms (7 Days Nett).

**If you have any queries or require further information please contact us on 0400 612 499 (24/7)**

PLEASE USE **BLACK INK** FOR REPRODUCTION PURPOSES

**COMPLETE ALL DETAILS & RETURN ASAP on Email: info@oceanglass.com.au**

Name of Business: \_\_\_\_\_ ABN#: \_\_\_\_\_

Address: \_\_\_\_\_

Postcode: \_\_\_\_\_ PH: \_\_\_\_\_

Accounts Payable Email address: \_\_\_\_\_

### INSURANCE POLICY DETAILS:

Policy Holders Name: \_\_\_\_\_ ABN#: \_\_\_\_\_

Postal Address of Policy Holder: \_\_\_\_\_

Postcode: \_\_\_\_\_

Policy Holders Contact Number: ( ) \_\_\_\_\_

Fax: ( ) \_\_\_\_\_

Email: \_\_\_\_\_

Mobile: \_\_\_\_\_

NAME OF YOUR INSURANCE COMPANY: \_\_\_\_\_

(Name of Insurance Company ONLY)

(Please **DO NOT** complete with Insurance Broker Details)

Policy Number: \_\_\_\_\_

Insurance Excess \$ \_\_\_\_\_

ITC Percentage on Premium applicable to this policy # \_\_\_\_\_ %

**CLAIM DETAILS:** Date of loss: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Time Of Loss: \_\_\_\_\_

Police Report #: \_\_\_\_\_

Claim #: \_\_\_\_\_

Cause of Damage: \_\_\_\_\_

Description of Repairs: \_\_\_\_\_

THE ABOVE WORK HAS BEEN CARRIED OUT TO MY SATISFACTION AND I/WE ACKNOWLEDGE THAT ULTIMATE RESPONSIBILITY FOR REPAYMENTS RESTS WITH ME/US SHOULD THIS CLAIM NOT BE ACCEPTED BY MY/OUR NOMINATED INSURANCE COMPANY. ANY EXCESS PERTAINING TO THE ABOVE MENTIONED POLICY WILL BE PAID DIRECTLY TO OCEAN GLASS AND GLAZING

I, the undersigned policy holder, give permission for all matters in relation to this claim for works completed by Ocean Glass be discussed with Ocean Glass administration. Please pay Ocean Glass direct on the behalf of the insured

NAME:..... POSITION HELD:.....

SIGNED..... DATED: ...../...../.....

**PLEASE ENSURE ALL DETAILS HAVE BEEN COMPLETED AND THIS CLAIM FORM HAS BEEN SIGNED**