

Policy No.____

Head Office: Telephone: Branch Office: Newtown Centre, 30-34 Maraval Road, Newtown, 190133, Trinidad & Tobago (868) 625-GGIL (4445) ■ Fax: (868) 622-9994 31-33 Independence Avenue, San Fernando, 600202, Trinidad & Tobago

Claim No.____

(868) 657-GGIL (4445) - Fax: (868) 652-5228 Telephone: Website: www.myguardiangroup.com

PLATE GLASS CLAIM FORM EACH OF THESE QUESTIONS MUST BE ANSWERED COMPLETELY

1.	Name of Insured					
Address						
	Telephone No					
2.	Business carried on therein					
3.	Address where breakage occurred					
4.	Date of breakage and/or damage mm/dd/yy					
5.	Cause of breakage and/or damage (Give fullest particulars of how breaka occurred)					
State name and address of the person causing breakage and/or damage, and of his employer, if any						
State the names and addresses of all witnesses of the breakage and/or damage						
8.	Were the premises occupied at the tir If not, on what date and at what hour occupied.					
		9. PARTICULA	RS OF BREA	AKAGE		
Number of	Whether Window	Kind of GI	366	Sizes in inches		Whether Cracked
Squares	Door, etc.	Broken		Height	Width	or Broken out
10.	State if immediate replacement is des Guarantee of Replacement at a future					
11.	Is the Glass insured with any other Colf so, state which	ompany?				

1:	12. Give full details of the damage caused to the shop front									
13. Name and address of firm which fitted shop front										
FIXTURES AND FITTINGS (If Insured) 14. Give full details of damage to fixtures and fittings in shop windows										
15. Give below full details of damage to stock in shop window,										
No	Description of Stock	From whom purchased	Date of Purchase mm/dd/yy	Cost Price	Amount Claimed					
Date_	Date Signature of Insured If Company Please Affix Company Stamp									

SHOP FRONT DAMAGE (If Insured)