Agostini Insurance Brokers Ltd.

119 Henry Street, Port of Spain, Trinidad, West Indies Tel: (868) 623-0576/9; Fax: (868) 624-9505
No.1 Freeling Street, San Fernando. Tel: (868) 652-3337; 652-3774 Fax: (868) 652-5541
Edoo's Building, 98 Norma Drive, Lowlands, Tobago Tel: (868) 639-2986; 639-3869; Fax 639-2986
Website: **www.agostini.com** Email: **aib@trinidad.net**

Public Liability Claim Form

(Please use block capitals and do not leave blanks or answer a question with a dash)

This form is NOT to be used for vehicular accidents. If the claim is in writing please forward with this form

Client Number _____ AIB Branch _____ Policy Number _____ Policy Renewal Date _____

INSURED INFORMATION

Name of Insured _____
Surname First Name Middle Name

Address of Insured _____
Street City County

Telephone Number (868)_____ (868)_____ Email Address _____
Primary Secondary

CLAIM DETAILS INFORMATION

State date and time of Accident _____
Date DD / MM / YYYY Time (Hour)

Location of Occurrence _____
Street City Country

Did you make a report to the police? YES ☐ NO ☐

If YES is checked above _____
Name of Police Officer Police Station Date of Notification

Give details of how the accident occurred

Describe fully the nature and extent of the injury and damage resulting to Third Parties

Name and Addresses of all witnesses (State if it is an employee or independent witness)

Name Address

Name Address

Name Address

Name Address

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Public Liability Claim Form (Continued)

(Please use block capitals and do not leave blanks or answer a question with a dash)

This form is NOT to be used for vehicular accidents. If the claim is in writing please forward with this form

CLAIM DETAILS INFORMATION

CLAIMANT INFORMATION

Name of Claimant _____

Surname First Name Middle Name

Address of Insured _____

Street City

Telephone Number (868)_____ (868)_____ Email Address _____

State the nature of the injury or damage

_____

_____

_____

_____

Have you received notice of a claim? YES ☐ NO ☐

If YES is checked above _____

Date Notified DD / MM / YYYY

Name and Addresses of the person or who was to blame for the accident

Name Address

Name Address

Name Address

Name Address

Name and Addresses of the person's employer if not you

Name Address

Name Address

Signature: _____

Print Name Signature

Date: _____