

INSURED'S DETAILS

Policy Number	<input type="text"/>		
Company Name	<input type="text"/>		
Company Registration No	<input type="text"/>	Email Address	<input type="text"/>
Address	<input type="text"/>		
Contact Number	<input type="text"/>	Contact Person	<input type="text"/>

DETAILS OF LOSS

When did the loss occur?	Date	<input type="text"/>	Time	<input type="text"/>	(eg 15h30)
Do you have internet security loaded on your device?	<input type="checkbox"/> Y	<input type="checkbox"/> N	If yes, please describe/identify	<input type="text"/>	
Have you previously suffered a loss as provided for in the policy?	<input type="checkbox"/> Y	<input type="checkbox"/> N	If yes, please provide details	<input type="text"/>	
Have you reported the loss to the financial institution / third party?	<input type="checkbox"/> Y	<input type="checkbox"/> N	Financial institution / third party reference number	<input type="text"/>	
Are you the sole owner of the device from which loss occurred?	<input type="checkbox"/> Y	<input type="checkbox"/> N	If not, please provide details of the other parties concerned	<input type="text"/>	
Amount of loss / unauthorised transaction?	<input type="text"/>				
Is the loss insured under any other policy?	<input type="checkbox"/> Y	<input type="checkbox"/> N	If yes, please provide details of the policy	<input type="text"/>	

Please provide a detailed description of how the loss occurred:
