



Sagicor General Insurance Inc.

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FIDELITY INSURANCE – CLAIM FORM

(PLEASE COMPLETE ALL DETAILS ON THIS PAGE / PLEASE WRITE IN BLOCK LETTERS AND TICK CORRECT ANSWER BOXES)

STATEMENT OF AND PARTICULARS OF CLAIM

Policy No.: Claim No.:

As requested, we are sending you this claim form.
Its early completion and return will help us to deal with the matter as quickly as possible.

Name of Insured:

Occupation:

Address:

Telephone No.: Business:

E-mail: Vat/B.I.R.#:

1. Name and address of insured (if different from above):
Telephone No.:

2. Name of employee responsible for loss:

3. (a) State the salary withheld from the above employee: \$
(Including any expenses and/or commission on items relating to this claim and on outstanding accounts)

(b) State any securities held in respect of the loss: \$

4. (a) Amount claimed before deducting amounts shown in question 3: \$

(b) How has the loss been calculated?

5. (a) When was loss discovered?

(b) State period over which loss has occurred?

6. Has the loss been reported to the Police?

If YES, state (a) address of station concerned:

(b) Is prosecution of employee likely?

(c) Name of investigating Police Officer:

7. How did the defaulter evade the system of check and supervision?

**continue overlead if necessary*

I/We declare that the sum claimed is the loss occasioned by the acts of fraud or dishonesty of the above employee and that no irregularities have previously occurred in the said employee's accounts.

Name of Insured: Signature of Insured: Date:

NOTE: The written references which you obtained when the defaulting employee was first engaged must be attached to this form when it is returned unless the society by agreement obtains such references on your behalf.