

CLAIM FORM



CUSTOMER INFORMATION (Please complete using information from your bill)

Name:	Telephone:	Cell:
Address:	City:	Postal Code:
Customer Account Number:	Email:	

INCIDENT DETAILS:

Date:	Time of Incident:	
Incident Location/Address:	City:	Postal Code:
Description of incident - be as specific as possible (if you require addition space, please attach separate page)		

DESCRIPTION OF ITEMS DAMAGED AND APPROXIMATE VALUE:

ITEM	CLAIMED AMOUNT (\$)

Do you have existing insurance that could cover the loss or damage?	Yes	No
If yes, please provide the name of the insurance company:		
Have you filed a claim with your insurance company?	Yes	No
If yes, please provide Claim Number and your deductible:	Claim Number:	Deductible:

PRINT NAME:	DATE:
SIGNATURE:	

Note: Any person who, with the intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement, is guilty of insurance fraud. While investigating your complaint, in accordance with the Municipal Freedom of Information and Protection of Privacy Act (MFIPPA), InnServices will only disclose your personal information to staff and service providers who require the information to perform the investigation. Your personal information will not be shared with anyone else unless you provide written consent for such sharing or where InnServices is compelled by law to do so. If you have any questions about the collection, use or disclosure, contact by email to: privacy@innservices.co.

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