

<b>Accident Report</b> <input type="checkbox"/> <b>CMR-Insurance</b> <input type="checkbox"/> <b>Cargo-Insurance</b>		asko-claim-no.	
<b>To</b>  Asko Assekuranzmakler GmbH Egerbach 58 a A-6334 Schwoich  ☎ +43 (0) 5372 / 6 24 60      ☎ +43 (0) 5372 / 6 24 24 Email: a-info@asko24.com      www.asko24.com		<b>Insurance Holder</b> (name, address and e-mail)    Policy-no.:	
Is it possible to correspond directly with opposite parties:      yes <input type="checkbox"/> no <input type="checkbox"/>		Your claim-no.: Certificate-no.:	
<b>Customer:</b> (name / city)		<b>Claimant:</b> (name / city)	
<b>Sender:</b> (name / city)		<b>Damaging party:</b> (name / city)	
<b>Recipient:</b> (name / city)		<b>Type of damage:</b> <input type="checkbox"/> partial loss / total loss <input type="checkbox"/> damage <input type="checkbox"/> cash on delivery <input type="checkbox"/> inventory difference <input type="checkbox"/> exceeding delivery time <input type="checkbox"/> other	
<b>Area of Damage:</b> <input type="checkbox"/> handling <input type="checkbox"/> warehouse <input type="checkbox"/> transport <input type="checkbox"/> part load <input type="checkbox"/> own responsibility <input type="checkbox"/> other			
<b>Probable claims amount in EUR:</b>		Regress possible?    yes <input type="checkbox"/> no <input type="checkbox"/>	
<b>Weight of damaged/lost goods (kg):</b>		Date of prime reclamation:	
<b>Type of goods:</b>		Value (EUR):	
<b>Date of dispatch:</b>		Dispatch-no.:	Date of damage:
Date of order:		Date of delivery:	Number plate truck:
Transshipment?      yes <input type="checkbox"/> no <input type="checkbox"/>		Loading by: <input type="checkbox"/> customer <input type="checkbox"/> driver <input type="checkbox"/> both	
Clear paperwork?      yes <input type="checkbox"/> no <input type="checkbox"/>		Offloading by: <input type="checkbox"/> recipient <input type="checkbox"/> driver <input type="checkbox"/> both	
Weight of shipment (kg):		Number of colli:	Police contacted? <input type="checkbox"/> yes (enclose report) <input type="checkbox"/> no
Surveyor?      no <input type="checkbox"/> yes <input type="checkbox"/> name and reference			
<b>Damage description (if applicable please enclose separate attachments):</b>          			
<b>Exception against the claim:</b> yes <input type="checkbox"/> (if yes, please explain the exception)    no <input type="checkbox"/>			
<b>Statement for the deductible:</b> The insurers are entitled, but not obliged, to claim the deductible for us in his own name. (if not, discard)		<b>Attachments:</b> <input type="checkbox"/> delivery receipt <input type="checkbox"/> claim report <input type="checkbox"/> way bill / CMR <input type="checkbox"/> forwarder invoice <input type="checkbox"/> survey report <input type="checkbox"/> order confirmation <input type="checkbox"/> liability bearing <input type="checkbox"/> pick up note <input type="checkbox"/> bill of lading <input type="checkbox"/> insurance certificate <input type="checkbox"/> cargo / packing list <input type="checkbox"/> commercial invoice <input type="checkbox"/> claim invoice <input type="checkbox"/> further	
<b>City:</b>	<b>Date:</b>		
<b>Signature:</b>			