CLAIM FORM
FIDELITY GUARANTEE INSURANCE

1)	Name and Address of the Contributor	:	
2)	Occupation of the Contributor	:	
3)	Policy Number	:	
4)	Date and time of Loss	:	
5)	Date of discovery of Loss	:	
6)	Name and address of the defaulting employee	:	
7)	Amount of loss sustained	:	
8)	Exact details of defalcation committed	:	
9)	Full details of duties of employees at the time of defalcation	:	
10)	When last audit was conducted at the place of defaulting employee's employment and by whom?	:	
11)	Has the contributor has any money, property or effects of the defaulting employee in his possession? If so give particulars	:	
12)	Has the employee any relative to the contributor and action taken against the employee?	:	
13)	Has the loss been reported to police? If so attach police report	:	

I/We hereby declare that the above information given is full and true to the best of my knowledge and belief.

Date : **Signature of the Contributor**

In case of any requirements or clarification, kindly contact our FGA Department Tel: 2477200 Ext. 189-190-191-192, Administration Department Fax: 2477100 , Technical Departments Fax: 2476174 , E-mail Address: info@aintakaful.com