



CORPORATE OFFICE: 8800 NE Underground Dr., Kansas City, Missouri 64161 • (816) 455-2208 • FAX (816) 452-3865 • Toll Free 1-877-887-0728 • shipgfe@shipgfe.com

LOSS & DAMAGE CLAIM

Company:

Claimant Claim ID:

Presentation Date:

Claim is hereby filled with the below carrier for:

Claimant	
Remit To:	
Contact:	Phone:
Email:	

in connection with the shipment described below:

Freight Bill (Pro) Number:

Shipment:

Delivery Date:

Carrier	Contact:	Carrier Claim ID:	Carrier Bill-of-Landing:	Carrier BOL Date:	Vehicle Number:	Phone:	Email:	Delivery Carrier:
Shipper		Point Shipped From:		Consignee:		Destination:		

Detailed Statement Showing How Claim Amount is Determined. (Product, Description, Invoice Cost and Amount of Articles)

Product ID	Product Description	Quantity	Price	Disposition	Weight	Catch Wt.	Release	Line Total
					Discount (-)			
					Freight Charges (+)			
					Additional Charges			
					Total Claim Amount:			

Currency shown in US DOLLAR (USD)

Supporting Documentation

Document	Document ID/Description	Last Update	File Stored
			<input type="checkbox"/>
			<input type="checkbox"/>
			<input type="checkbox"/>

Comments:

Note:

Preparer's Name:

Claims Administrator:

Signature: _____