



Claims

Claimant:

FSP Airway Bill #:

Company:

Claim Date:

Address:

Claimant's Reference:

City:

State:

Zip:

Contact Name:

State:

Zip:

Telephone:

Email:

Shipper:

Consignee:

Company:

Company:

Contact Name:

Contact Name:

Address:

Address:

City:

State:

Zip:

City:

State:

Zip:

Shipper Ref#:

Consignee Ref#:

Ship Date:

POD Date:

Total Pieces:

Total Weight:

#of Pieces:

Description of Articles including Model #, etc.:

@ Standard Cost.:

Box #(s):

Reason for Claim.:

Weight:

Cost of Repair or Replacement and Detailed.:

Additional Information:

Total Claim Amount:

Signature: