STATEMENT OF CLAIM

ALERT
THIS CLAIM MAY BE REPORTED TO THE NATIONAL HOUSEHOLD GOODS CLAIM REGISTRY

Copyright © 1997, National HHG Registry, All Rights Reserved.

BEKINS VAN LINES, LLC
P.O. Box 2017
LaGrange, IL 60525

Phone: 800-7-BEKINS
Fax: 708-547-2274
Email: hhgclaims@bekins.com

BILL OF LADING # *

Please use this form to register a claim for loss or damage to items as a result of an INTERSTATE move by Bekins Van Lines, LLC. Damaged or missing claims must be filed and received within nine (9) months from delivery. If this was a Corporate Relocation, please refer to your compnay's contract for claims filing guidelines. If this was a Military Relocation, please refer to the Military Rules and Regulations for claim filing guidelines. Warranty or Delay claims must be filed within 30 days from delivery and may be in letter form with attached receipts for professional lodging and food. **Please follow the Instructions below:**

1. Complete ALL boxes highlighed with information for prompt handling of your claim.
2. Identify all item(s) and type of damage. Include: Inventory Number(s), Weight of Item(s), Original Cost, Date Acquired and Amount Claimed. Failure to provide all information may delay the claim process or result in denial of your claim.
3. For lost items list contents of containers and include evidence of ownership and value.
4. Include/Attach copies of your Order for Service, Bill of Lading and Inventories.
5. Sign, date and return to address or e-mail address above

DO NOT DISCARD DAMAGED ITEMS OR CRUSHED CARTONS/BOXES.
DO NOT PROCEED WITH ANY REPAIRS OR REPLACEMENTS UNTIL THE ADJUSTER MAKES THE NECESSARY DETERMINATION.

Claimant Name *				**Primary Phone ***	
Street Address *				**Alternate Phone**	
City *					
State *		**Zip ***		**Loading Date**	
E-mail Address				**Delivery Date**	
Coverage Selected **$.60 Pound**		Enter "X" in the box		**Storage Dates/Location**	
For All Its Worth				**Cartons Packed By**	
Amount		**Deductable**		**Cartons Unpacked By**	

Inventory #	Item *	Nature of Claim *	Estimated Weight	Item Cost	Amount Claimed
					0.00
** Required Fields*				**Total**	

By making this claim, the undersigned hereby warrants that he/she is authorized to submit this claim on behalf of the shipper/consignee, and hereby consents to the disclosure of the information provided herein and all other information about the claim to the National Household Goods Claim Registry ("NHGCR") and to any participating members of the NHGCR.

INFORMATION CONTAINED IN THIS CLAIM IS TRUE AND ACCURATE AND CONSTITUTES MY ENTIRE CLAIM FOR LOSS OR DAMAGE.

Type/Sign Name *		Date *	

Retain One Copy for your Records