Print Form

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New Hamburg, Ontario N3A 1A2

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Email:claims@erbgroup.com

STANDARD CLAIM FORM

DATE: _____/_____/_____ **CLAIMANT'S CLAIM #** _____
M D Y

CLAIMANT NAME: _____

(REMIT TO)
ADDRESS: _____

_____

_____

_____

PHONE: _____ **FAX**: _____

EMAIL: _____

This claim in the amount of $_____ is hereby filed against

The Erb Group of Companies for: **Loss**: ☐____ **Damage**: ☐_____**Other**: ☐_____
(Check one)

In connection with the shipment described below.

Shipper: _____ **Consignee**: _____

Origin: _____ **Destination**: _____

Erb Pro # _____ **Date of Pick up**: _____

Erb OS&D # _____ **Bill of Lading and/or P.O #** _____

The foregoing statement of facts is hereby certified to be correct.

Claimant Name: _____ **Signature**: _____

NOTE: CLAIMS MUST BE FILED WITHIN 60 DAYS FROM THE DATE OF DELIVERY