



Claim Notice of Loss Form

(Effective Nov 2019)

Please complete each of the sections below that are applicable.
Fields marked with an asterisk (*) are required.

| Reported By | | | |
|---|--|------------------|--|
| Title: | *First Name: | *Last Name: | |
| Company Name: | | | |
| Mailing Address: | Street/Post Office Box: | | |
| | City: | State/Province: | |
| | *Country: | Zip/Postal Code: | |
| *What is the best way to contact you? | Telephone | eMail | |
| *Contact Info: | | | |
| Reference Number: | | | |
| Role in Relation to Loss: (Please check one) | Insured/Policy Holder Insured Agent/Broker Claimant Claimant Agent/Broker Other: | | |



| Insured/Policy Information | | |
|--|--|--|
| *Insured / Policy Holder Name: | | |
| Policy Number: | | |
| Insurance Company Name: | | |
| Type of policy (If known, check most applicable): | | |
| <input type="checkbox"/> Auto/Motor | <input type="checkbox"/> General/Public Liability | <input type="checkbox"/> Property |
| <input type="checkbox"/> Workers Compensation | <input type="checkbox"/> Accident & Health | <input type="checkbox"/> Marine |
| <input type="checkbox"/> Art | <input type="checkbox"/> Equine/Livestock | <input type="checkbox"/> Aerospace |
| <input type="checkbox"/> Cyber | <input type="checkbox"/> Professional/Financial (D&O, E&O) | <input type="checkbox"/> Environmental/Pollution |
| <input type="checkbox"/> Other: | | |
| Insured Contact (Only complete if different than reporter noted above) | | |
| Title: | First Name: | Last Name: |
| Mailing Address: | Street/Post Office Box: | |
| | City: | State/Province: |
| | Country: | Zip/Postal Code: |
| Telephone Number (including country and area code): | | |
| Email Address: | | |



Claimant(s) Information

Check if this is the same as insured/policy holder. If not, please complete as many of the fields below as possible.

| | | |
|---|-------------------------|------------------|
| Title: | First Name: | Last Name: |
| Mailing Address: | Street/Post Office Box: | |
| | City: | State/Province: |
| | Country: | Zip/Postal Code: |
| Telephone Number (including country and area code:) | | |
| Email address: | | |

Claim Contact (Person we should contact first about loss)

- Reporter
 Insured
 Other (If "other", please complete fields below)

| | | |
|---|-------------------------|------------------|
| Title: | First Name: | Last Name: |
| Company Name: | | |
| Mailing Address: | Street/Post Office Box: | |
| | City: | State/Province: |
| | Country: | Zip/Postal Code: |
| Telephone Number (including country and area code:) | | |
| Email Address: | | |

Please send completed form and any related correspondence to the email address noted below based on your region/country.

| Region / Country | Email Address | Region / Country | Email Address |
|---------------------|--------------------------------|-------------------------------|------------------------|
| North America / All | WEBFNOL.NA@axaxl.com | UK / All (Motor Claims) | NEWCLAIMS@axaxl.com |
| EMEA / France | WEBFNOL.EMEA.FRANCE@axaxl.com | UK / All (Non-motor Claims) | WEBFNOL.UK@axaxl.com |
| EMEA / Germany | WEBFNOL.EMEA.GERMANY@axaxl.com | South / Central America / All | WEBFNOL.EMEA@axaxl.com |
| EMEA / Italy | WEBFNOL.EMEA.ITALY@axaxl.com | APAC / All | WEBFNOL.APAC@axaxl.com |
| EMEA / All Other | WEBFNOL.EMEA@axaxl.com | | |

Any person who knowingly and with intent to defraud any insurance company or other person files an application for commercial insurance or a statement of claim for any commercial or personal insurance benefits containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, and any person who in connection with such application or claim, who knowingly makes or knowingly assists, abets, solicits or conspires with another to make a false report shall be subject to criminal and civil penalty..