



CLAIM FORM

Date: _____

Name of Claimant:	Name of Carrier: NORTHLAND SERVICES, INC.
Address:	Address: P.O. BOX 24527
City, State, Zip:	City, State, Zip: SEATTLE, WA 98124
Telephone Number:	Telephone Number: (206) 763-3000
Email:	Fax: (206) 508-7635

This claim for \$ _____ is made against the carrier named above by _____ for:

Loss

Damage in connection with the following described shipments of paid Freight Bill (Pro) Number _____

Name of Shipper:		Final Destination – Name of Consignee:	
Address:		Address:	
Shipped from	City, State:	Voyage No.	Booking No.
To:	City, State::	Date of B/L:	Date of Delivery:
If Shipment reconsigned en route, state particulars:			PO No.:

DETAILED STATEMENT SHOWING HOW AMOUNT OF CLAIM IS DETERMINED

(Number & description of articles, nature & extent of loss or damage, invoice price of articles, amount of claim, etc.)

LOST CARGO VALUE OR DAMAGE REPAIR COSTS:	\$
COST OF FREIGHT:	
TOTAL AMOUNT CLAIMED	\$

IN ADDITION TO THE INFORMATION GIVEN ABOVE, THE FOLLOWING DOCUMENTS ARE SUBMITTED IN SUPPORT OF THIS CLAIM:

- | | |
|--|---|
| <input type="checkbox"/> 1. Original bill of lading, if not previously surrendered to carrier. | <input type="checkbox"/> 4. Photographs or facsimiles to depict nature and extent of damage |
| <input type="checkbox"/> 2. Original paid freight (expense) bill. | <input type="checkbox"/> 5. Other particulars obtainable in proof of loss or damage claimed |
| <input type="checkbox"/> 3. Original invoice or certified copy. | |

Explain the absence of any documents listed in Items 1 – 4 above: _____

WHEN, FOR ANY REASON, THE ORIGINAL PAID FREIGHT BILL OR BILL OF LADING IS NOT PROVIDED, CLAIMANT MUST INDEMNIFY CARRIER OR CARRIERS AGAINST POSSIBLE DUPLICATE CLAIMS SUPPORTED BY ORIGINAL DOCUMENTS.

INDEMNITY AGREEMENT

When the original bill of lading and/or freight bill is not submitted, or is not available for submission, but copies of the original are submitted in support of the claim described above, the claimant agrees to indemnify and hold harmless the carrier receiving this claim, named above, and any participating carriers, and will pay to the carrier or any participating carrier all losses, costs, damages, counsel fees or any other expenses it (the carrier) may incur resulting from all lawful subsequent duplicate claims arising out of the same shipment which may be filed and supported by the original documents.

Foregoing statements of fact are hereby certified as true and correct.

_____	_____
Date	Name of Claimant
_____	_____
Signature of Claimant	Street Address
_____	_____
	City, State, Zip