



RISK PROFILE QUESTIONNAIRE

We hereby declare that the details supplied below are true and complete and that no material fact has been withheld. This form does not bind the Insured to effect this insurance, but it is agreed that this form shall be the basis of the contract should the client accept and a cover note be issued.

Freight Operator: ACT LOGISTICS		Contact Name: CHERYL OREILLY
Phone No: 0219512009	Fax No: 0219512013	E-mail: cheryl@act-logistics.co.za

Full Name of Insured: (Company requesting insurance)	Account Number with FO:
	Status (new, existing or Adhoc client of ACT):
Contact Person:	E-mail address:
Phone No:	Fax No:
Vat No:	Postal Address:

General Description of Business:

Description of the goods being sent (please list all types of cargo that you intend freighting).	New or used goods
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Detail of Packing Pallets/boxes etc

Routing: (from where to where town not address)	Services:
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<p><u>BASIS OF VALUATION:</u> (How you arrive at your insured value, to which a premium rate will be applied)</p> <p><u>NOTE:</u></p> <ul style="list-style-type: none"> • The following are recommendations designed to ensure sufficient indemnity in the event of a loss. • The following formulas are not compulsory but are strongly suggested. • Please confirm your chosen Basis of Valuation in the space provided below. <p><u>Exports:</u> Cost, Insurance and Freight plus 20%.</p> <p><u>Imports:</u> Delivered Cost at final destination (including duty where applicable) plus 20%</p>

Basis of Valuation: Please indicate your selection from the above
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Maximum Value at Risk: (conveyance and storage factored)

Estimated Annual Sum to be Insured:
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Any additional information:

Once completed please return to:	E-mail: insurance@myact.co.za	Fax No: 0219512009
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