STANDARD FORM FOR PRESENTATION OF LOSS AND DAMAGE CLAIM

TO: ***Shelba D. Johnson, Trucking, Inc.***
P. O. Box 7287
High Point, NC 27264
PH: 336-476-2000
FAX: 336-476-9310

_____
DATE

_____
CLAIMANT NUMBER

_____
CARRIERS PRO NUMBER

THIS CLAIM FOR $_____ IS MADE AGAINST YOUR COMPANY FOR **( ) LOSS(ES) ( ) DAMAGE(S)** IN CONNECTION WITH THE FOLLOWING SHIPMENT.

_____ Shipper Name	_____ Consignee Name
_____ Shipper Address	_____ Consignee Address
_____ City / State / ZIP	_____ City / State / ZIP

IF SHIPMENT WAS RECONSIGNED EN ROUTE, STATE PARTICULARS: _____

DETAILED STATEMENT SHOWING HOW AMOUNT OF CLAIM IS DETERMINED

Description of Claim *(PLEASE GIVE ITEM NUMBER, COMMODITY DESCRIPTION, NUMBER OF PIECES CLAIMED, AMOUNT BEING CLAIMED.* ***ALL DISCOUNTS AND ALLOWANCES MUST BE SHOWN)***	**Amount(s)**

NMFC Item No.: _____ Total Amount of Claim: _____

( ) Original Bill of Lading
( ) Original invoice or certified copy
( ) Consignee concealed loss or damage form
( ) Carrier.s Inspection Report Form (Concealed loss or damage)
( ) Original paid freight bill or other carrier document bearing notation of loss or damage if not shown on freight bill
( ) Shipper.s concealed loss or damage form
( ) Other particulars obtainable in proof of loss or damage claimed (list below):

_____

(*NOTE:* The absence of any documents called for in connection with this claim must be explained. When impossible for claimants to produce original bill of lading or paid freight bill, a bond of indemnity must be given to protect carrier against duplicate claim supported by original documents.)

INDEMNITY AGREEMENT

In the absence of the Original Freight Bill and/or Original Bill Of Lading, we agree to hold the above named carrier to whom this claim is presented and any other participating carrier, harmless and indemnified against any and all lawful claims which may be made against it or them arising out of the same shipment and will pay to the said carrier and any participating carriers(s), all losses. damages, costs, counsel fees or any other expenses which they or any of them may suffer or pay by reason of payment of our claim, herein described, without the surrender of the original Freight Bill or Bill Of Lading, as such was not provided and/or cannot be located.

Note: If the section below is not filled out completely, it is very possible that your claim WILL NOT be processed.

The foregoing statement of facts is hereby certified as correct.

_____ *PERSON FILLING OUT THE CLAIM FORM*	_____ *COMPANY NAME*
_____ *CLAIMANT SIGNATURE AND TITLE*	_____ *COMPANY ADDRESS*
_____ *TODAYS DATE*	_____ *PHONE NUMBER / FAX NUMBER*

_____
E-MAIL ADDRESS

ALL CLAIM FORMS MUST BE FAXED TO 336-476-9310 OR MAILED TO THE ADDRESS ABOVE