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FAX COVER SHEET

TO: Claims Department			FROM:		
COMPANY: Holland			DATE:		
FAX NUMBER: 877-236-0843			TOTAL PAGES INCLUDING COVER:		
PHONE NUMBER: 616-395-5180			CARRIER REFERENCE NUMBER:		
EMAIL: claims@hollandregional.com			YOUR REFERENCE NUMBER:		
ADDRESS: 750 EAST 40 TH ST			ADDRESS:		
CITY: HOLLAND	STATE: MI	ZIP: 49423	CITY:	STATE:	ZIP:

<input type="checkbox"/> URGENT	<input type="checkbox"/> FOR REVIEW	<input type="checkbox"/> PLEASE COMMENT	<input type="checkbox"/> PLEASE REPLY
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NOTES/COMMENTS:

Holland PH: 616-395-5180 750 East 40 th St Holland MI 49423	Claims Department Fax: 877-236-0843	PRESENTATION OF OVERCHARGE CLAIMS
claims@hollandregional.com		PLEASE USE EITHER MAIL OR FAX—NOT BOTH

Click in document to complete form.

Claimant Name:	Date:
Claimant Address:	*Claimant's Number
Carrier Name: HOLLAND	Carrier's Number (for carrier use only):

THIS CLAIM FOR \$ _____ IS MADE FOR OVERCHARGE IN CONNECTION WITH THE FOLLOWING DESCRIBED SHIPMENTS:

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Name of Overcharge/Authority for (weight, rate, or class, etc):

DETAILED STATEMENT OF CLAIM

Note: If claim covers more than one item taking different rates and classifications, attach separate statement, showing how overcharge is determined and insert totals in space below.

PRO NUMBER	DATE mm/dd/yyyy	AMOUNT PAID	CORRECT AMOUNT	OVERCHARGED (CLAIMED) AMOUNT
TOTAL				

Remarks:

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

<input type="checkbox"/>	Original paid freight bill	<input type="checkbox"/>	Weight certificate or certified statement when claim is based on weight.
<input type="checkbox"/>	Original invoice, or certified copy, when claim is based on weight or valuation, or when shipment has been improperly described.	<input type="checkbox"/>	Other particulars obtainable in proof of overcharge claimed.
<input type="checkbox"/>	Original bill of lading if not previously surrendered to carrier when shipment was prepaid or when claim is based on misrouting or valuation.		

BOND OF INDEMNITY: The undersigned guarantees to protect any carrier having an interest against any and all loss, costs and expenses, including attorney fees, which may result from payment of this claim by reason of our failure to support same with original paid freight bill.

The Foregoing statement of fact is hereby certified as correct. Signature: X _____

* Please assign a claim number to this claim. Refer to this claim number in all future correspondence.

** Place a check next to supporting documents that are attached. If a form is not attached, please explain in the "Remarks" section. If you cannot produce an original bill of lading or a paid freight bill, carrier is indemnified against any duplicate claims supported by the original documents.