

**EQUIPMENT (ROAD VEHICLE) CLAIM FORM**  
 (The issue of this form is not to be taken as an Admission of Liability)

**CLAIM NUMBER:**

**1. Important Instructions:**

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| <p>a. Claim form is to be filled in capital letter &amp; signed by the Insured.</p> <p>b. Please do not leave any column unanswered.</p> <p>c. All facts and statements must be factual and not influenced or biased in any form.</p> <p>d. The damaged vehicle must be parked at a safe place to avoid any subsequent loss/theft. Company will not be responsible for the same.</p> |
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**2. Policy Holder Details**

Policy No.: .....	
Period of Insurance: From.....	To.....
Name of the Insured:	Phone Off:.....
Address:	
Contact Person:	Mobile: .....
..... PIN: .....	E Mail: .....

**3. Vehicle Details**

Regd. No.: .....	Make:.....	Date of 1 <sup>st</sup> Registration:.....
Chassis No.:.....		Engine No.:.....
Colour of Vehicle:.....		

**4. Loss Details (Accident/Theft)**

Date:.....	Time:.....	Speed:.....
Exact Place where loss occurred:.....		
Place to which the vehicle was heading for before the accident :.....		
Purpose for which vehicle was being used at the time of accident:.....		
Nature of goods, if any, carried at the time of accident (Comm. Veh.):.....		
No. of people traveling and in what capacity at time of accident: .....		
Is it reported to the Police? YES/NO		
Name of the Police Station:.....Gen. Diary/Crime/FIR No.:.....		

2.

Location of accident		Purpose of Travel at the time of accident	
	Yes / No		Yes / No
Express Way	<input type="checkbox"/> <input type="checkbox"/>	Business / Office	<input type="checkbox"/> <input type="checkbox"/>
National Highway	<input type="checkbox"/> <input type="checkbox"/>	Pleasure	<input type="checkbox"/> <input type="checkbox"/>
State Highways	<input type="checkbox"/> <input type="checkbox"/>	Domestic	<input type="checkbox"/> <input type="checkbox"/>
City roads	<input type="checkbox"/> <input type="checkbox"/>	Social	<input type="checkbox"/> <input type="checkbox"/>
Town/Village Roads	<input type="checkbox"/> <input type="checkbox"/>	MILEAGE at the time of accident .....	
Private Roads	<input type="checkbox"/> <input type="checkbox"/>		

5. Statement of how the Accident / Theft occurred:

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6. Give a rough sketch describing the road map and position of the vehicle at the time of accident.

7. Driver Details

Name: \_\_\_\_\_ Relation with Insured: \_\_\_\_\_

Address: (if different from the one mentioned above) Contact No.: \_\_\_\_\_

\_\_\_\_\_ Date of birth as shown on the license

Driving License No: \_\_\_\_\_ License Effective from: \_\_\_\_\_

Issuing RTO: \_\_\_\_\_ License expiry date: \_\_\_\_\_

Class: MCycle/LMV/HGV/Transport/Non-Transport Type: Permanent/Learners

3.

8. Occupant/Passenger/Third Party Injury Details if any

S. No.	Name	Address	Phone No.	In what	Capacity	Nature of Injury

9. Third Party Property Damage (Include other vehicle involved)

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10. Estimated Cost of Repairs : (Please attach Repair Quotation, if available)

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**Declaration:**

1. I/We the above named, do hereby, to the best of my/our knowledge and belief, warrant the truth of the foregoing statements in every respect and agree that if I have made any false or fraudulent statement of there be any suppression or concealment, the policy shall be cancelled and the claim shall be forfeited.
2. I/We have received a list of documents with this claim form and have understood all the requirement to be fulfilled for administration of this claim and the Company shall not be held responsible for any delay in settlement of claim due to non-fulfilment of requirements including the documents as mentioned above.
3. I/We agree to provide additional information to the Company, if required.

Name:

Signature of the Insured

Date: