



MOTOR CLAIM FORM - COMMERCIAL VEHICLE

THE ISSUE OF THIS FORM IS NOT TO BE TAKEN AS AN ADMISSION OF LIABILITY

INSTRUCTIONS FOR FILLING THE FORM

(a) Complete the form fully without leaving any relevant information. (b) Where check boxes provided tick the appropriate relevant box. (c) Where multiple boxes, fill one letter per box

CLAIM NUMBER (Office Use)																				
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POLICY NUMBER																				
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POLICY PERIOD	From	D	D	M	M	Y	Y	To	D	D	M	M	Y	Y
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INSURED NAME																				
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INSURED'S ADDRESS																							
																Pincode							
	Mobile																						
	STD Code								Landline														
E-Mail																							

VEHICLE TYPE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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VEHICLE DETAILS	Registration Number																				
	Registration Date	D	D	M	M	Y	Y	Year of Manufacture													
	Chassis Number																				
	Engine Number																				
	Make												Model								
	Hypothecation Details																				

CLAIM TYPE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																	
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DATE & PLACE OF LOSS	Date of loss	D	D	M	M	Y	Y	Y	Y	Time	H	H	M	M	a.m. / p.m				
	Place of Accident / Theft																		

LOSS DESCRIPTION	Provide brief description of accident / theft / occurrence. (Attach separate sheet if required):																			
	Draw a rough sketch of the accident location (Provide Road / Street names along with landmark)																			

DRIVER DETAILS	Person driving was	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	If driver, years of service																
	Driver Name																				
	Driver Address																				
	Driving Licence Number																				
	Licence Issue Date	D	D	M	M	Y	Y	Issuing RTA													
	Licence valid from date	D	D	M	M	Y	Y														
	Licence valid up to date	D	D	M	M	Y	Y														
	Type of license	<input type="checkbox"/> Temporary / <input type="checkbox"/> Permanent			Vehicle types licensed to drive																
	Was driver under influence of drugs / intoxicants	<input type="checkbox"/>	<input type="checkbox"/>	Was driver injured	<input type="checkbox"/>	<input type="checkbox"/>															



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ADDITIONAL LOSS DETAILS	Tractor, Lorry, Jeep (Additional Info)	Trailer attached	<input type="checkbox"/> Yes <input type="checkbox"/> No	PURPOSE FOR WHICH VEHICLE USED AT THE TIME OF LOSS <input type="checkbox"/> Personal use <input type="checkbox"/> Hire <input type="checkbox"/> Reward <input type="checkbox"/> Rallies <input type="checkbox"/> Reliability trials <input type="checkbox"/> Others (specify)	
	Commercial Vehicle (Additional Info)	Registered laden weight	<input type="text"/>		Kg
		Registered unladen weight	<input type="text"/>		Kg
		Weight of goods carried	<input type="text"/>		Kg
	Passenger Vehicle (Additional Info)	Type of Goods carried	<input type="text"/>		
Nature of goods carried		Hazardous / Non-hazardous			
Permit / Fitness Certificate Details (For Goods & Passenger vehicle)	Registered carrying capacity	<input type="text"/>			
	Passengers carried	<input type="text"/>			
	Nature of permit	<input type="checkbox"/> Temporary <input type="checkbox"/> Permanent			
	Type of permit	<input type="checkbox"/> Local <input type="checkbox"/> National <input type="checkbox"/> Inter State <input type="checkbox"/> Others (specify)			
	Permit valid for area(s)	<input type="text"/>			
Details of other insurance policy that indemnify this accident.	Permit valid up to	<input type="text"/>	<input type="text"/>		
	Fitness valid up to	<input type="text"/>	<input type="text"/>		

WORKSHOP DETAILS	Location where vehicle can be inspected	<input type="text"/>		
	Address of Workshop / Location	<input type="text"/>		
	Workshop Contact	<input type="text"/>	Contact Mobile	<input type="text"/>
	Workshop Phone	<input type="text"/>	Workshop Fax	<input type="text"/>
	Workshop E-mail	<input type="text"/>	Loss Estimate	<input type="text"/>

THIRD PARTY LOSS DETAILS	Third party involved	<input type="checkbox"/> Yes <input type="checkbox"/> No	(If "Yes", provide additional information)							
	Third party loss type	<input type="checkbox"/> Death <input type="checkbox"/> Injury <input type="checkbox"/> Property Damage								
	Details of Third party loss (Attach separate sheet)	Name	Age	Loss type	Address	Treatment Undergone	Hospital Details	Phone	Third Party Vehicle Number (If applicable)	Remarks
		<input type="text"/>		<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Witness Details	Name	Address		Phone						
<input type="text"/>		<input type="text"/>		<input type="text"/>						

THEFT DETAILS	<input type="checkbox"/> Theft of vehicle <input type="checkbox"/> Theft of accessories	(If accessories stolen provide detail as below in a separate sheet)			
	Accessory Name	Make & Brand	Serial Number	Accessory Insured	Accessory IDV
				Yes / No	Rs.

FIR DETAILS (Applicable for theft, fire & third party loss only)	Loss Reported to police	<input type="checkbox"/> Yes <input type="checkbox"/> No	If No provide reasons <input type="text"/>		
	Date of loss intimation to police	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
	Police station location	<input type="text"/>			
	FIR / Crime diary number	<input type="text"/>			
	First Information Report Date	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

INSURED BANK DETAILS	Account number	<input type="text"/>										
	Bank Name	<input type="text"/>					Branch Name	<input type="text"/>				
	IFSC Code Number	<input type="text"/>										

DECLARATION BY INSURED

I/We the above named, do hereby, to the best of my / our knowledge and belief, warrant, the truth of the foregoing statement in every respect, and I / We agree that I / We have made, or in any further declaration the company may require in respect of the said accident, shall make any false or fraudulent statement, or any suppression or concealment the policy shall be void and all rights to recover thereunder in respect of past or future accidents shall be forfeited.

Date: Place:

Signature of Insured / Claimant