Intimation Cum Preliminary Claim Form – Auto Policy

Please keep the information handy before ringing up the 24X7 call center at
1800-119966 or SMS CLAIMS to 58888

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

PLEASE SIGN ON BOTH SIDES OF CLAIM FORM. DO NOT LEAVE ANY COLUMN UNANSWERED.

Claim No. _____ Policy no. _____

Vehicle No. _____ Eng No._____ Chassis No._____

INSURED/CLAIMANT NAME: _____email:_____

Address: _____

_____City_____Pin_____

Mob _____ Tel Res _____ Tel off _____

Time & Date of Accident / Occurrence_____Hrs D D M M Y Y Y Y Place of Accident _____

Type of Loss (details overleaf) ☐ OWN DAMAGE ☐ THIRD PARTY ☐ Bodily Injury ☐ Property

Damage Short Description of Accident/Incidence (Sketch overleaf) _____

_____

_____

To be filled only in case of commercial vehicle

Permit valid upto _____ Fitness valid upto_____

Load carried at the time of accident _____ No. of passengers carried at the time of accident _____

Police FIR no. (lodged if any)_____ Police Station_____

Details of the driver at the subject time of accident

- Name _____ Age _____ Occupation_____
- Driver is ☐ Owner ☐ Paid Driver ☐ Relative/ Friend
- Driving License No. _____ Badge no _____
- Effective for (type of vehicles)_____Effective upto:_____

Please enclose self – certified copies of Registration Certificate, Driving License, Fitness & Permit Certificate (by the insured as applicable). Also please enclose copies of Police Report and Fire Brigade Report, if lodged.

DECLARATION

I/We agree to provide additional information to the Company, if required. 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 if 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.
I understand that the Company reserves the right of verification of facts and documents relating to the policy and claim.

Place _____

Date: D D M M Y Y Y Y

Signature of the Insured

CLAIMS DEPARTMENT
Tata AIG General Insurance Company Ltd.
Peninsula Business Park, Tower- A, 15th Floor, G.K. Marg, Lower Parel, Mumbai – 400013, Maharashtra, India

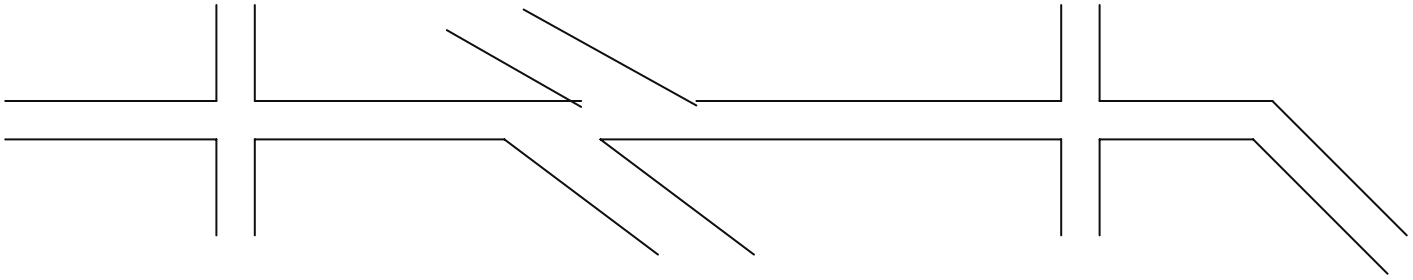
P.T.O

DETAILS OF DEATH/INJURY/PROPERTY DAMAGE TO THIRD PARTIES/OCCUPANTS/DRIVER

Sr no	Name of Third Party/Occupant/Driver	Address (Village/Town)	Contact No.	Type of Injury/ Damage	Name of the Hospital where admitted	Doctor Attending	Any Legal/Court Notice Recd.

N.B. Please attach additional sheet with full particulars, if needed.

Show how the accident occurred by using this diagram



Give street names, direction and location of objects concerned

DECLARATION

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