

**Claim form for Motor Vehicle
(TO BE FILLED BY OWNER OF VEHICLE)**

(The issue of this form is not to be taken as an admission of liability please answer all questions fully)

For claim Number please call on Toll Free Number 1800 2666

INFORMATION ABOUT INSURED :POLICY / COVER NOTE NO. _____ CLAIM NO. _____	
Name	_____
Correspondence Address	_____
_____	_____
_____	_____
_____	District _____ Pin Code _____
Res. Tel. No. _____	Off. Tel. No. _____
Fax No. _____ (Mobile Number & Email ID is essential for the Insurer to keep the customer informed about claim process)	
Mobile _____	E Mail Id _____

Average yearly income	<input type="checkbox"/> <3 lac	<input type="checkbox"/> 3 lac to 5 lac	<input type="checkbox"/> 5 lac to 10 lac	<input type="checkbox"/> 10 lac to 20 lac	<input type="checkbox"/> >20 lac
Occupation	<input type="checkbox"/> Service	<input type="checkbox"/> Marketing	<input type="checkbox"/> Non Marketing	<input type="checkbox"/> Business	<input type="checkbox"/> Others _____
No. of members there in your Family	<input type="checkbox"/> <2	<input type="checkbox"/> 2-4	<input type="checkbox"/> 4-8	<input type="checkbox"/> >8	
How many of them are above 18	<input type="checkbox"/> <2	<input type="checkbox"/> 2-4	<input type="checkbox"/> 4-8	<input type="checkbox"/> >8	
How many of them drive the vehicle	_____				
How many vehicle do you have	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> >2		
Average kms run in year	<input type="checkbox"/> <5000	<input type="checkbox"/> 5000-10000	<input type="checkbox"/> 10000-20000	<input type="checkbox"/> >20000	
How many times you claimed in last 2 years	<input type="checkbox"/> none	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3 or more	
Usage	<input type="checkbox"/> Personal	<input type="checkbox"/> Business (within city)	<input type="checkbox"/> Business (Outside city)		
Antitheft Device in the Vehicle	<input type="checkbox"/> None	<input type="checkbox"/> Immobilizer	<input type="checkbox"/> Gear Lock	<input type="checkbox"/> Tracking Device	

INFORMATION ABOUT INSURED VEHICLE :	
Registration No. _____	Make _____ Model _____
Date of Registration _____	Mileage _____ kms _____
Chassis No. _____	Engine No. _____
Class of Vehicle	<input type="checkbox"/> Private <input type="checkbox"/> Commercial <input type="checkbox"/> Two Wheeler
Hypothecation / Hire purchase agreement _____	

DETAILS ABOUT THE DRIVER (At time of accident)

Name _____

Correspondence Address _____

Driver is Owner Paid driver Relative/Friend If paid driver, how long has he been in your employment? _____ yrs.

Was he under the influence of intoxicating liquor or drugs? Yes No

Driving license number _____ Issuing authority _____

Date of expiry |D|D|/|M|M|/|Y|Y|Y|Y|

Driving license type HGV LCV LMV Motor Cycle Scooter without Gear

Details of endorsements, suspension if any _____

Was the license temporary? Yes No Details of endorsements, suspension if any _____

DETAILS OF ACCIDENT :	
Date D D / M M / Y Y Y Y	Time H H : M M am/pm
Exact location of accident (Address / Spot of Accident with landmark) _____	
Give brief description of the accident _____	

Was any third party responsible / liable for the accident? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, please provide a copy of FIR Details _____	

