

LIABILITY INSURANCE CLAIM FORM

(Issuance of this form does not imply acceptance of the liability)

If a Loss or Damage has occurred or become known, the Company must be notified immediately.

Claim No:		Policy No:
1	a) Name of the Insured b) Address of the Insured c) Telephone Number d) Business e) Period Of Insurance f) Limits of Indemnity under the Policy:	
2	Brief details as to the exact circumstances under which the loss occurred	
	a) Date and time of occurrence of loss b) Place of Accident c) Brief description of the kind and history of the occurrence d) When did you first come to know of the accident	

	<p>e) When was the accident reported to you?</p> <p>f) When was the claim first notified to the Insurer?</p>	
3	<p>Particulars of Consequence of the Accident:</p> <p>a) Has any person sustained any injuries in the accident? If so</p> <p>1) Give name(s) of such person(s)</p> <p>2) Address</p> <p>3) Occupation</p> <p>4) State where such person(s) was/ were at the time of accident</p> <p>5) Has/ Have the injured person(s) been removed to hospital or medically attended?</p> <p>If So give particulars</p> <p>b) Has the accident caused damage to</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>

	<p>property or livestock?</p> <p>If so, give name(s) and address(es) of the owner(s) of the property and / or livestock, and full description of the property, and state the nature and extent of damage</p> <p>c) Has any claim been made upon you by any person? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If so, state by whom and give full particulars (attach a copy of the notification received and of the bill, if submitted</p> <p>d) Estimated amount of claim separately under a, b, and c</p> <p>e) Give, if possible, the names of all witness to the accident</p> <p>f) Has the accident been reported to any authority?</p> <p>If so, state to whom and attach a copy of the report submitted</p> <p>g) What action, if any, has been taken by the authority?</p>	
		<p>Name</p> <p>Address</p>

	h) Give details of statute / Law under which in your opinion, liability may arise	
4	<p>Details of Other Insurances:</p> <p>Give details of other Insurances, if any, covering the present loss</p>	
5	<p>Details of Previous Losses:</p> <p>Give details of previous claims, if any, on the same item</p>	

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 I/We agree that if I/We have made or in further declaration the company may require in respect of the said accident, shall make any false or fraudulent statement, or any suppression or concealment, my /our claim shall be absolutely forfeited and the Policy shall be null and void.

Date:

Place:

Authorised Signatory