

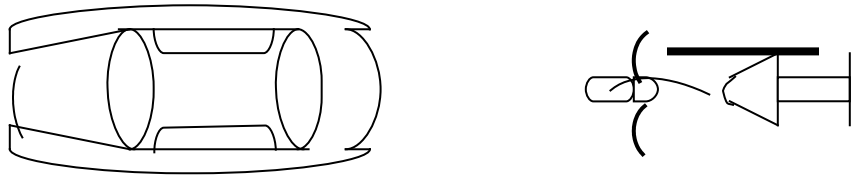
MOTOR CLAIM FORM**THE NEW INDIA ASSURANCE COMPANY LIMITED**

(Incorporated in India)

**“Please do not give any Third Party any information of particulars which you are not required by law to give and in no case admit your fault or make any payment or offer of payment without the written authority of the company.
Answer all questions FULLY. It will avoid unnecessary correspondence and consequent delay in the settlement of claim.**

The Issue of this form is not an admission of a claim

Name of Insured			
Address			
Occupation and Tel No.			
Policy or Certificate No. :		Date of premium paid :	
Expiry Date :		Receipt No :	
Driver (These details must be given Whosoever was driving)			
me			
Address			
His driving licence particulars:-			
{a} No	{b} Date of expiry	{a}	{b}
{c} Groups	{d} Is it Provisional	{c}	{d}
How long has he held a full driving licence?			
Details of his previous Motoring convictions and any pending prosecutions. If none. State "NONE"	Date	Offence	Fine, endorsement etc.
Does driver suffer from any defective vision or physical infirmity?			
Was vehicle being driven with your knowledge and permission?			
The driver's relation to the Policy holder.			If employee, since when
Does driver own any other vehicle? Give name of Insurer and Policy No			
Has any Insurance company or underwriter refused or declined to continue any motor insurance for the driver?			
Was he under the influence of intoxicating liquor or drugs?			
Your Vehicle		Reg. No. _____ H.P. or C.C _____ Year _____ Make & Model _____ Colour of Body _____ Engine No. _____ Chassis No _____ Present Value _____ Type and description of body _____ Approx. Mileage _____	
If a motor cycle and 50cc or under Is it pedal assisted?			
Is it subject to Hire Purchase?		Name or co.	
Describe in full the purpose for which your vehicle was being used			
If vehicle not owned by you give name and address of owner.			
Give brief details of your damage			
Estimated cost of repair..... (The repairer's detailed estimate should be sent as soon as possible).			
Subject to policy cover do you wish to claim for your damage? (A claim under our policy may affect your No Claim Discount)			
Have you notified details by telephone? If not, where can vehicle be inspected by our Engineer?			
IF COMMERCIAL VEHICLE, STATE			
(1) Nature of goods carried	(1)	(2)	
(2) Amount of load carried			
(3) Owner of goods	(3)	(4)	
(4) Any Trailer attached?			

ACCIDENT DETAILS									
Did police attend? If not were they informed? If so, at which police station?									
How far from near side kerb was your vehicle?									
Width of road									
What road signs or warnings were: (a) On your road?									
(b) Other vehicle?									
What lights were given:- (a) Your vehicle?									
(b) Other vehicle?									
Were streets lights illuminated?									
Speed of your vehicle									
Weather conditions									
Was your vehicle traveling on the major road?									
Which speed limit was applicable?									
Have you seen or written to the claimant or any person acting on claimant's behalf?									
Have you received any summons or notice of intention to prosecute arising from this accident?									
POINT OF IMPACT TO YOUR VEHICLE									
OTHER OWNER/DRIVER									
Name									
Address									
Make and No. of Vehicle									
Insurers (name and address)									
Policy No.									
DETAILS OF INJURED PERSONS									
Please Give name, age and	(1)								
Nature of injury	(2)								
	(3)								
	<table border="0"> <tr> <td colspan="2" style="text-align: center;">CATEGORY OF INJURED PERSONS</td> </tr> <tr> <td>Your vehicle</td> <td style="text-align: center;">T.P.Vehicle</td> </tr> <tr> <td>Passenger <input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/> Pedestrians <input type="checkbox"/></td> </tr> <tr> <td>Driver <input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/> Cyclist <input type="checkbox"/></td> </tr> </table>	CATEGORY OF INJURED PERSONS		Your vehicle	T.P.Vehicle	Passenger <input type="checkbox"/>	<input type="checkbox"/> Pedestrians <input type="checkbox"/>	Driver <input type="checkbox"/>	<input type="checkbox"/> Cyclist <input type="checkbox"/>
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Passenger <input type="checkbox"/>	<input type="checkbox"/> Pedestrians <input type="checkbox"/>								
Driver <input type="checkbox"/>	<input type="checkbox"/> Cyclist <input type="checkbox"/>								
DETAILS OF DAMAGE TO OTHER PERSONS VEHICLE OR PROPERTY									
	(1)								
Please give owner and	(2)								
Extend of damage	(3)								

Any summons of communication received from a Third Party should be passed to us immediately.

LOSS DECEIPTION (ACCIDENT THEFT OR FIRE)	DATE	Time
Place (street or road and town)		
Witnesses (name and address) (1)		
Please tick box right hand side if (2)		
witness a passenger in your vehicle (3)		
(4)		

ANSWER THE FOLLOWING IN CASE OF THEFT

What precautions were taken by you to prevent loss? _____

Who was in charge of vehicle at the time of theft
And for what purpose was it being used? _____

At what station were the Police notified and when? _____

Have you any clue to the thief? _____

Particulars of articles stolen	When and where bought	Price Paid	Actual Value at time of theft	Amount claimed

Where the stolen articles (a) actually in the car when stolen? _____ (b) your own property? _____

State what other insurances are in force upon the lost property _____

SKETCH PLAN

Please show road measurements and the positions of the parties and the course taken by them leading up to accident.

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 any further declaration of the Company require in respect of the said accident, shall make any false or fraudulent statements or any suppression or concealment of Policy shall be void and all rights to recover there under in respect of past or further accident shall be forfeited.

Witness: _____

Signatures of Insured: _____

Date: _____

Date: _____