

WITNESS DETAILS

1. Were there any witnesses to the loss/accident?

Yes No

If 'Yes',

2. Name as Person/s

S U R N A M E M I D D L E N A M E F I R S T N A M E

3. Address

Plot No/Door No. Building Name
Road Area
City Pincode
State

4. Contact Details

Phone No. Mobile
E-mail Id

INFORMATION TO AUTHORITY

1. Has the loss been reported to an Authority?

Yes No

If 'No', reason for not reporting

If 'Yes', provide details

Fire Police Municipality Other

2. Name of Authority

3. Information Report No./ Authority Reference No.

Date D D M M Y Y Y Y

4. Contact Person/s

S U R N A M E M I D D L E N A M E F I R S T N A M E

5. Address

Plot No/Door No. Building Name
Road Area
City Pincode
State

6. Contact Details

Phone No. Mobile
E-mail Id

C. DETAILS OF OTHER INSURANCE

1. Is the loss / damage covered under any other Insurance?

Yes No

If 'Yes', specify details and attach a copy of the policy

Name of Insurer

Address

Plot No/Door No. Building Name
Road Area
City Pincode
State

Contact Details

Phone No. Mobile
E-mail Id

Policy Number

Sum Insured

Period of Insurance

From D D M M Y Y Y Y To D D M M Y Y Y Y

F. DETAILS OF PREVIOUS LOSSES

Losses during the 3 preceding years

| Date of Loss | Claim Description and Cause of Loss | Value of Loss (Rs.) | Insurer |
|--------------|-------------------------------------|---------------------|---------|
| | | | |
| | | | |
| | | | |

G. DETAILS OF OTHER INFORMATION

Do you wish to provide any other information?

Yes No

If 'Yes', specify

DECLARATION

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 make in any further declaration, the Company may require in respect of the said accident, 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, and all rights to recover there under in respect of past or future loss/accident shall be forfeited.

Place

Date:

Signature of Insured/Claimant _____

Name of Insured/Claimant _____