United India Insurance Company Limited

Corporate Identity Number: U93090TN1938GOI000108
Registered Office: 24 Whites Road, Chennai – 600014
IRDAI REG NO.545

CLAIM FORM
Carrier's Legal Liability Insurance Policy

Policy No.:
Policy Period:
Claim No.:

The issue of this Form is not to be taken as an admission of liability.

1	**Name of Insured:**	
2	**Details of Insured Vehicle:**	
	a) Registration No.	
	b) Make and Year of Built	
	c) Name of the owner	
	d) Whether Insured comprehensively under Motor Policy	
	e) If yes, please give name & address of insurer, policy no. & place of issue	
3	**Details of Goods/ Cargo**	
	a) Nature of goods carried	
	b) Weight of goods carried	
	c) Place of dispatch	
	d) Total No of cases and/or packages dispatched	
	e) Full details of condition of case and / or packages taken delivery of	
	d) Value of the goods	
	e) Name of Consignor/ Consignee	
4	**Details of Accident**	
	a) Date & Time	
	b) Place	
	c) Nature & cause of accident	
	d) When was the accident reported to you ?	
	e) If any third party was responsible for the accident, pl give name & address	
5	a) No. of packages damaged/ destroyed	
	b) Quantum of loss	
	c) Whether any claim has been made upon you by third party in respect of damage to goods carried	
	d) If so, state by whom and give full particulars (If claim has been	

	made in writing attach a copy of notification received.	
6	a) Give the names and addresses of all witness to the accident.	
	b) Has the accident been reported to any authority? If so, state to whom and pl attach a copy of the report.	
	c) If not reported, reason thereof.	
	d) What action, if any, has been taken by the authority ?	
	e) Give particulars, of any other insurance If any, in respect of the same risk.	

I / We the above named do hereby, to the best of my knowledge and belief declare the truth of the foregoing statements in every respect: and I/ We agree that if I/We have made or in any further declaration the company may require in respect of the said accident, shall make a false or any suppression or concealment my/ our claim shall be absolutely forfeited, and the policy shall be null and void.

Place:
Date:

Signature of Insured:
Name: