UNITED INDIA INSURANCE COMPANY LIMITED

ANIMAL DRIVEN CART POLICY
CLAIM FORM

(The issue of this form does not constitute admission of liability. Please return this form completed within 14 days of the loss together with the relevant documents.)

Policy No. Claim No.

1	a) Name of insured: b) Address: c) Business / Occupation: d) Name of other persons having an Interest in the property
2	DETAILS OF INSURANCE(INCLUDING THE POLICY/POLICIES TAKEN WITH OUR COMPANY)

Policy No. (s)	Sum Insured Rs.	Period	
		From	To
N.B. If Insurance is effected with other Companies, copies of such policies to be attached.			

3	**SECTION I - ANIMAL & CART / VEHICLE** **A) LOSS OR DAMAGE TO CART / VEHICLE -DETAILS OF LOSS / EVENT** a) Time & Date of Loss / Event b) Cause of Loss / Event c) Item of Policy effected (give description) d) Describe in detail the total event giving rise to the claim e) Has the event / loss been reported to Police or other Authorities? f) Estimate of repairs to the cart / vehicle. g) Name of repairer. **B) INJURY TO ANIMAL** a) Was the animal injured due to any accident or event? If so, give full description of the accident / event. b) Was the animal given veterinary treatment? If so, by whom. c) Was the animal disabled due to the said accident? If so, describe the nature of disablement supported by the attending Veterinary Doctor.	

4.	**SECTION - II THIRD PARTY LIABILITY** a) Date hour and place of accident b) Cause of accident (Full information) c) Nature and extent of injury or damage d) Name, address and age of injured person/s e) Particulars of accidental bodily injury of the injured f) Name and address of owner of third party property damaged g) Is he / she in your service h) Details of compensation expected i) Has any communication, verbal or written made to you for any claim from third party? If so, give particulars. j) Details of compromise made if any. k) When and by whom was the accident reported to you? l) Has the accident been reported to Policy or Public Authority? m) Name/s and address/es of the witnesses to the accident.	
5.	**SECTION - III PERSONAL ACCIDENT TO DRIVER** **DETAILS OF LOSS / EVENT** a) Time & Date of Loss / Event b) Cause of Loss / Event c) Describe in detail the total event giving rise to the claim d) Has the event / loss been reported to Police or other Authorities? e) Name of the driver and age. f) Was the driver removed to hospital immediately after the accident? g) If yes, name and address of the hospital. h) Nature of injury suffered by the driver due to the accident. i) Result of the medical treatment i.e. whether the driver was disabled due to the accident and if so, the nature of disablement duly certified by the hospital. j) Name and age of the assignee in case of death of the driver. k) Relationship with the diseased driver. l) Full address of the assignee. m) Have you enclosed death certificate and post-mortem report? If so, please attach the same.	

I/We hereby declare that the statement made by us in the claim form are true to the best of our knowledge and belief and that I / We have to withheld any material information which has bearing upon the claim.

Place:

Date: **Signature of the Claimant**

ANIMAL DRIVEN CART INSRANCE – MEDICAL REPORT
(FOR DISABLEMENT CLAIM OF DRIVER)

(This form is to be completed and signed by the Medical Attendant)

1.	Name and Address of Insured Person:	
2.	What was the injury?	
3.	a) When did you first attend on the Insured person following the injury? b) Are you still attending on him?	a) b)
4.	Are you his usual Medical Attendant? If you have treated him for any previous illness or injury, please give details:	
5.	a) According to you, how long the Insured Person was confined to bed/house as the direct and sole consequence of the above injury? b) During this period was the Insured Person able to attend to any portion of his normal duties? If so, from what date: c) If not, please state probable period of convalescence after which he can resume his normal duties fully.	a) b) c)
6.	Any other remarks you wish to make:	

I hereby certify the Insured Person mentioned above has suffered from the disease mentioned above and that I have treated him for the said disease.

Place:

Date:

Seal / Rubber Stamp

Signature:

Name:

Address:

Qualifications:

Regn. No.

Note: The fee, if any, for this Report will be borne by the Insured Person