

UNITED INDIA INSURANCE COMPANY LIMITED

CLAIM FORM - DAIRY PACKAGE INSURANCE

(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.)

Po.	licy No.				Claim No	•								
1.	a) Name of	insured:												
	b) Address													
	c) Business or Occupation:													
	d) Name of other persons having an													
	Interest in	n the property												
2.	DETAILS C	F INSURANC	E (Includi	ng the Policy / Policies taken w	ith our Co	mpany)	<u>, </u>							
			Policy No	. (s)	Sum Ir	sured	Pε	eriod						
	Rs.													
							From	То						
	N.B. If Insur	rance is effected	with othe	r Companies, copies of such po	licies to be	attach	ed.							
3.	SECTION I	- DAIRY CAT	TLE - D	ISCRIPTION OF ANIMAL (CLAIMED	FOR								
		,												
	Description	Identification	Species	Sex (If female whether	Exact	Milk	•	Value						
	of Animal	Tag No.	&	pregnant calf at foot, freshly	Age in	prior		prior to						
		Colour	Breed	carved or heafer	years	illnes	S	illness						
		as the animal firs												
		as notice sent to												
		st and last seen l	by veterina	arian?										
	4. Date of A	Attendance.												
	5. Name &	Address of Vete	erinary Sur	geon who attended.										
		death, with date	and hour.											
	7. Cause of	death;												
	If from d	isease, how do y	ou accour	nt for it?										
	If from a	ccident, how did	l it occur a	nd who was in charge?										
	If operate	ed upon recently	, state nati	are and date and also name of										
	Surgeon.													
	Was any p	oost-mortem cor	nducted? I	f so, please attach the Report.										
	Please att	tach the enclose	d Veterina	ry Certificate vide Annexure I										
	duly con	npleted and sign	ned by the	Veterinary Surgeon.										
	8. Purpose f	for which used o	r employe	d when last at work.										
	9. Did you b	breed or buy the	animal?											
	10. Date of la	ast carving:												
	State who	ether the animal	is dry or p	oregnant.										
	If pregna	nt, what is the st	tage of pre	gnancy.										
	11. Amount of claim.													
	12. Is the year	ar tag of the anim	nal enclose	ed										
	13. Is the ani	mal insured else	where?											
	Are you receiving compensation from any other source? If so, from whom													
	and detai													
	14. a) If animal has not died, describe the nature of injury / YES OR NO													
	disease and state when it occurred and its duration.													
				l in permanent capacity										
		•		ed or for purpose of										
		-	-	If so, give details										
		rted by Veterina	-											
		-		fter the injury / disease										
			t the perm	anent in capacity as										
	descri	bed above?												

UNITED INDIA INSURANCE COMPANY LIMITED

4.	SECTION - II FIRE & ALLIED PERILS		
	DETAILS OF LOSS / EVENT		
	a) Time & Date of Loss / Event		
	b) Cause of Loss / Event		
	c) Item of Policy effected (given 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) Fire / Meteorological / Police Report to be attached.		
	Extent of Loss (as more particularly described in the Statement overleaf along		
	with the necessary documents and bills)		
5.	SECTION III - PUMP SET	(a)	
5.	a) Description of the Pump set:	(a)	
	i) Make / Model		
	ii) Year of Manufacture		
	iii) Suction		
	,		
	v) Amp/Volts		
	vi) Rating vii) Situation of the pump set with Survey No.		
	b) Cost Price	(h)	Rs.
		(b) (c)	Rs.
6.	c) Replacement Cost SECTION IV - MACHINERY BREAKDOWN FOR MECHANICAL	(C)	NS.
0.	GADGETS		
	DETAILS OF LOSS / EVENT		
	a) Time & Date of Loss / Event		
	b) Cause of Loss / Event		
	,		
	c) Item of Policy effected (given description) d) Describe in detail the total event giving rise to the claim		
	d) Describe in detail the total event giving rise to the claim a) Hes the event / less been reported to Police, or other. Authorities?		
	e) Has the event / loss been reported to Police or other Authorities?		
	f) Extent of Loss (as more particularly described in the Statement overleaf) g) Name of the Repairer		
	, I I		
7.	i) Salvage value offered SECTION V - MONEY - IN- TRANSIT		
7.	Full particulars of circumstances surrounding the loss		
	Particulars of loss of money denomination-wise and details of cash on hand as		
	per receipts.		
	Details of Safe or Cupboards / Cash box kept in the premises and keys		
	operation procedure practiced.		
	Details of violence / assault leading to hold up risk and loss of money.		
8.	SECTION VI - JANATA PERSONAL ACCIDENT		
0.			
	Please complete and return the JPA claim form attached herewith vide		
	Annexure II along with Medical / Hospital Certificate		

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

CLAIM FORM DETAILS OF CLAIM FOR PROPERTY / LOST / DESTROYED OR DAMAGED

The insurance is based on the principle of indemnity only and all claims must be based upon the actual value of the goods at the time of event excluding any value addition whatsoever.

Item Number of	Description of	•	Value	at	the	Deduction for value of	Net Amount
Policy	Affected /	Lost	time		of	salvage, wherever applicable	Claimed
	Property		event	/	lost	Rs.	Rs.
			Rs.				

ANNEXURE I

CLAIM FORM - DAIRY CATTLE

VETERINARY CERTIFICATE

I hereby certify that the animal described below, the property of Mr/Mrs./Miss of							
died on the	of and that I attended the said animal from the	day of					
until the day of							

DESCRIPTION OF ANIMAL

Description of Animal		Identifi -cation / Tag No.	Species & Breed	Sex (if female Whether Pregnant calf at foot, freshly calved or heifer) colour & full distinguishing marks	Exact age in years	Height	Value prior to illness Rs.
1							
1.		u make a erse of the		em? If so, give detailed report			
2.	Cause	of death					
3.	If from	disease, h	ow do you	account to it?			
4.				it occur and nature of injuries			
	sustaine	ed					
5.	If from	an operati	on, give d	ate and nature of operation			
6.	Had the	e animal ha	ad every ca	are and attention?			
7.	Did yo animal		e for Insur	rance and do you identify the			
8.	4. If a dise 5. Has inca pur 6. Did so, the	nimal has ease and st s the ir apacity to pose for w I you treat what was permanen	not died, ate when injury/disea conceive of hich it is in the anima the nature t incapacit urpose for				
9.	Salvage	e Value		Rs.			

I hereby	warrant	the	truth	of	my	answers	respecting	the	above	animal	death	and	I	know	of	no	material
information which has been withheld.																	

	Signature:
	Qualification:
Date:	Name & Address:

This form should be completed without delay and forwarded direct to the Company.

Seal:

^{*} Strike out whichever is not applicable

ANNEXURE II

JANATA PERSONAL ACCIDENT INSURANCE - CLAIM FORM

POI	POLICY NO. CLAIM NO.									
SEC	SECTION I (TO BE FILLED IN FOR ALL CLAIMS)									
1.	a) Insured's Name									
	b) Address									
	c) Age									
2.	a) Policy No.									
	b) Period									
	c) Issued at				1					
3.	a) Particulars of Accident:	Date	Time	Place	Whether reported					
	b) Details		A.M./P.M.		to police Yes/ No.					
4.	a) Were you removed to hosp		•	Yes / No	O					
	b) If yes, Name & address o									
5.	a) Do you have any other Ja	natha Person	al Accident Policy?	Yes / No	O					
	If yes, please give:									
	b) Name of the company									
	c) Address of the issuing of	fice								
	d) Policy No.									
	e) Period									
SEC	CTION II (TO BE COMPLE	ETED BY HO	OSPITAL AUTHORITII	ES)						
1.	Name & address of the Hosp	ital		As in –	patient / out patient /					
	emergency case									
2.	· ·									
3.	Date of discharge									
4.	. a) Nature of injury									
	b) Particulars of treatment									
5.	. a) Has the accident resulted into loss of hand/s or foot/feet or eye/s									
	or permanent disability of any other type which may prevent the									
	Insured from engaging in	_								
	attention to any employme		tion whatsoever?							
	b) If yes, please give details									

Signature of the Competent Authority of

Hospital / Nursing Home

Date: Name: Rubberstamp of Hospital: Designation:

SECTION III (TO BE COMPLETED BY ASSIGNEE IN THE EVENT OF INSURED'S DEATH)								
Details of Assignee								
a) Full Name								
a) Address								
b) Age								
c) Relationship with the deceased								
	Signature of the Assignee							
Date:								
Please attach the following documents:-								
a) Death Certificate								
b) Post Mortem Report								
c) Original Policy document with receipt								

Declaration to be signed by the Insured/ Claimant or by the Assignee (in the event of Insured's death).

I/WE HEREBY DECLARE and warrant the truth of the foregoing particulars in every respect. I / We agree that if / I / we have made, or if, shall make false or untrue statement, suppression or concealment, my/our right to compensation shall be forfeited.

I/WE ALSO HEREBY DECLARE that I am /we are accepting the amount in full discharge of your obligations under the policy to the Insured and / or his/her legal heirs and I/we will hold you indemnified in the event of any claim under this policy being made against you by any other person or persons.

Date: Signature