

Intimation Cum Preliminary Claim Form – Auto Policy

Please keep the information handy before ringing up the 24X7 call center at
1800-119966 or SMS CLAIMS to 58888



WITH YOU ALWAYS

THE ISSUE OF THIS FORM IS NOT TO BE TAKEN AS AN ADMISSION OF LIABILITY.

PLEASE SIGN ON BOTH SIDES OF CLAIM FORM. DO NOT LEAVE ANY COLUMN UNANSWERED.

Claim No. _____ Policy no. _____
Vehicle No. _____ Eng No. _____ Chassis No. _____

INSURED/CLAIMANT NAME: _____ **email:** _____

Address: _____

_____ City _____ Pin _____

Mob _____ Tel Res _____ Tel off _____

Time & Date of Accident / Occurrence _____ Hrs DDMMYYYY Place of Accident _____

Type of Loss (details overleaf) OWN DAMAGE THIRD PARTY Bodily Injury Property

Damage Short Description of Accident/Incidence (Sketch overleaf) _____

To be filled only in case of commercial vehicle

Permit valid upto _____ Fitness valid upto _____

Load carried at the time of accident _____ No. of passengers carried at the time of accident _____

Police FIR no. (lodged if any)

Police Station

Details of the driver at the subject time of accident

- Name _____ Age _____ Occupation _____
- Driver is Owner Paid Driver Relative/ Friend
- Driving License No. _____ Badge no _____
- Effective for (type of vehicles) _____ Effective upto: _____

Please enclose self – certified copies of Registration Certificate, Driving License, Fitness & Permit Certificate (by the insured as applicable). Also please enclose copies of Police Report and Fire Brigade Report, if lodged.

DECLARATION

I/We agree to provide additional information to the Company, if required. I/We the above named, do hereby, to the best of my/our knowledge and belief, warrant the truth of the foregoing statement in every respect, and if I/We have made, or in any further declaration the Company may require in respect of the said accident, shall make any false or fraudulent statement, or any suppression or concealment, the policy shall be void and all rights to recover thereunder in respect of past or future accidents shall be forfeited.

I understand that the Company reserves the right of verification (*) of facts and documents relating to the policy and claim.

Place _____

Date: DDMMYYYY

Signature of the Insured

CLAIMS DEPARTMENT

Tata AIG General Insurance Company Ltd.

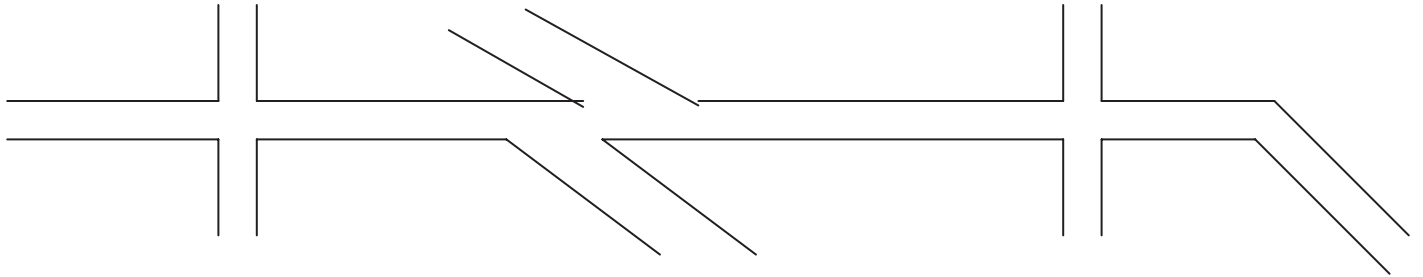
A-501, 5th Floor, Building No. 4, Infinity Park, Gen. A. K. Vaidya Marg, Dindoshi, Malad (East), Mumbai - 400 097. P.T.O

DETAILS OF DEATH/INJURY/PROPERTY DAMAGE TO THIRD PARTIES/OCCUPANTS/DRIVER

Sr no	Name of Third Party/Occupant/Driver	Address (Village/Town)	Contact No.	Type of Injury/Damage	Name of the Hospital where admitted	Doctor Attending	Any Legal/Court Notice Recd.

N.B. Please attach additional sheet with full particulars, if needed.

Show how the accident occurred by using this diagram



Give street names, direction and location of objects concerned

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Signature of the Insured

CLAIMS DEPARTMENT

Tata AIG General Insurance Company Ltd.

A-501, 5th Floor, Building No. 4, Infinity Park, Gen. A. K. Vaidya Marg, Dindoshi, Malad (East), Mumbai - 400 097.
(Regd. Office : Peninsula Corporate Park, Nicholas Piramal Towers, 9th Floor, G K Marg, Lower Parel Mumbai - 400013)