



UNITED INDIA INSURANCE COMPANY LIMITED

Head Office: 24, WHITES ROAD, CHENNAI - 600014

CARRIER LEGAL LIABILITY CLAIM FORM

Pol. No

Period

Claim no.....

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

The completion and return of this form to the company should not be delayed if any of the particulars required not be immediately given. They may be forwarded to the company afterwards as soon as possible.

1. INSURED

(a) Name of the Insured _____

2. INSURED VEHICLE

- (a) Registration No.
- (b) Make and year of Built
- (c) Name of the owner
- (d) Whether Insured comprehensively.
- (e) Under Motor Policy.
- (f) If yes, give name and address of
Insurance Co. & Policy No/
Place of Issue

3. GOODS

- (a) Nature of goods carried
- (b) Weight of goods carried
- (c) Place of despatch
- (d) Place of destination
- (e) Total No of cases and/or
packages despatch
- (f) Full details of condition of case
and / or packages taken delivery of
- (g) Value of the goods
- (h) Name of the Consigner/Consignee

4. PARTICULARS OF ACCIDENT.

- (a) Date and time
- (b) Place
- (c) Nature and cause of accident
- (d) When was the accident reported to you
- (e) If any third party was responsible for

the accident, give name and 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. attach a copy of the report.
(c) If not reported, rest thereof
(d) What action, if any, has been taken by the authority ?

7. 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.

Witness	:	Signature.....	Signature of the Insured
		Name.....	
		Address.....	Date:
		
		

Date: