

**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**



**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.**

Ahura Centre, 4<sup>th</sup> Floor, 82, Mahakali Caves Road, Andheri (E), Mumbai-400093

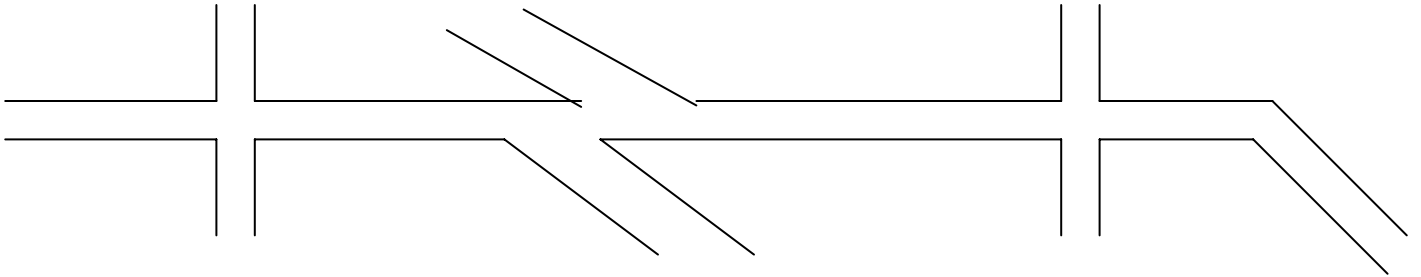
P.T.O

**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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Place \_\_\_\_\_

Date: D D M M Y Y Y Y

Signature of the Insured

CLAIMS DEPARTMENT

**Tata AIG General Insurance Company Ltd.**

Ahura Centre, 4<sup>th</sup> Floor, 82, Mahakali Caves Road, Andheri (E), Mumbai-400093. Fax: +91 22 56938171  
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