



THE NEW INDIA ASSURANCE CO LTD.
P.O.BOX 2907, PC 112, RUWI
SULTANATE OF OMAN

MOTOR CLAIM FORM

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

Policy No:..... Period of Insurance:.../.../.....to.../.../.....

Insured Name:

Tel Nos:..... Res:..... G.S.M :.....

Regn.No:..... Vehicle Make:..... Model:.....

Engine No.:..... Chassis No :.....

Was the vehicle in proper working condition:.....

For what purpose was the vehicle
being used at the time of accident:.....

Full details of damages:.....

Estimated cost of repairs:.....

When and where the damaged vehicle can be inspected:.....

DRIVER DETAILS

Name of driver at the time of accident:.....

Date of birth:...../...../..... Age:years

Driving License Number:..... Date of Issue :...../...../.....

Date of Expiry.....:/...../..... Issuing Authority:.....

Is the driver 1- Owner 2 - Paid Driver 3-Owner's relative of friend

If paid driver, how long has been in your employment?.....

Was he under the influence of intoxication liquor or drugs?.....

Has he been involved in any accident before?.....

Type of vehicles authorized to drive:.....

ACCIDENT DETAILS

Date:..... Time:..... Place:.....

Speed of your vehicle at the time of accident?.....

Give a short description of the accident:.....

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THIRD PARTY PROPERTY DAMAGE

TP Vehicle Regn. No:..... Make:..... Model:.....

Full details of property damaged:.....

THIRD PARTY PERSONAL INJURY

Was driver/ any occupant injured:.....

Names of Injured Persons:	Type of Injury	Contact Numbers
1.....
2.....
3.....
4.....
5.....

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 I / We agree 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 there under in respect of past or future accidents shall be forfeited.

Date:/...../.....

Signature of the Insured