BAJAJ ALLIANZ GENERAL INSURANCE COMPANY LTD.

Claim Form

PLEASE ANSWER EVERY QUESTION AND FULLY

The issue or acceptance of this form is not to be construed as admission of liability on the part of the Company

Regional/Branch Office Code			
Broker/Agent Name & code		Code	

Insured Details

1. Name of the Insured													
2. Address of the Insured	Plot No/Door No.		Building name										
	Road												
	Village												
	City		Pin code										
	State												
	Phone No.												

Details of Cattle in respect of which claim is made

Details of the Cattle	Type of Cattle	Sex	Age	Breed	Description of the Cattle				Identification Tag No.	**Insured's estimate of Market Value.**
		M/F	Years		Colour	Horns	Tail Switch	Distinguishing Features	Rt/Lt Ear	Rs.

Details of the Claim- Cover 1

1. Nature of Disease contracted.	
2. Date Disease was first detected	
3. Details regarding treatment of Disease.	
4. Name of Vet attending and Performing Post-mortem	
5. a) Date of the Death b) Cause of Death c) How and where did the accident happen?	

Details of the Claim- Cover 2

6. a) Nature of Permanent Total Disability b) Certificate from Vet obtained? If yes, please attach.	
6. Name & address of the Vet who issued the Certificate of Soundness	
7. Name & address of the Hospital where treatment is taken/being taken	
8. Do you have any other Cattle Insurance Policy? If Yes, give details.	

I/We hereby declare that the foregoing statements are true in all respects and that I/We have not attempted to conceal from the company anything with which it ought to be made acquainted. I/We confirm my/our understanding that if I/we have made or will make in any further declaration the Company may require any false or fraudulent statement or suppression or conceal any material fact or advance any untrue fact whatever, the Policy shall be void and my/our right to compensation forfeited and I am/ we are willing if required, to make a statutory Declaration before a Justice of the Peace of the truth of the whole of the foregoing statement or any other statement I/We may make in connection with this claim.

Signature of the Insured
Date ……..
Address …….