

	Workshop Mobile:		Workshop Phone:						
	Workshop Fax:		Workshop E-mail:						
Theft Details	Theft of Vehicle:								
	Theft of Accessories: (If accessories stolen provide detail as below in a separate sheet)								
	Accessory Name	Make & Brand	Serial No	Accessories Insured Yes/No					
			Accessory IDV – Rs.						
FIR Details (Applicable for theft, fire, loss of personal effects & Third party loss only)	Accident/Theft reported to police: Yes/No		(If No provide reasons)						
	Date of reporting to Police:								
	Name of Police Station:								
	FIR/Crime diary number:								
Third Party Loss Details	Third Party involve : Yes/No		If "yes", provide information:						
	Third party loss type:	Death :Yes / No	Injury: Yes / No	Property Damage: Yes / No					
	Driver Injured : Yes/No		Occupants Injured : Yes/No						
	Details of third party loss:								
	Name	Age	Loss type	Address	Treatment undergone	Hospital details	Phone	Third party vehicle number (if applicable)	Remarks
Witness Details:									
Name		Address		Phone					
Add On Covers (if applicable)	Courtesy Car facility availed: Yes / No		If yes, completion date:						
	Medical Expenses : Yes / No		Likely Expenses:						
	Loss of Personal Effects: Yes / No		(List item lost with value as separate sheet, FIR Mandatory)						
	Return to Invoice Cover: Yes/ No								
	Engine and Gear Box Protection Cover: Yes/ No								
	Nil Depreciation Add On Cover: Yes/ No								
Insured bank Details	Account No.								
	Bank Name:		Branch Name:						
	IFSC Code No.								
DECLARATION BY THE INSURED									
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 that 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.									
Date:									
Place:									
Signature of Insured / Claimant									