

REGD. OFFICE:
BHARTI AXA GENERAL INSURANCE COMPANY LIMITED

First Floor, The Ferns Icon, Survey No. 28,
Next to Akme Ballet, Doddanekundi,
Off Outer Ring Road, Bangalore- 560037,
Toll-Free Helpline: 1800-103-2292

E-mail: claims@bharti-axagi.co.in

SMS <CLAIM> to 5667700

Website: www.bharti-axagi.co.in



general insurance

MONEY IN TRANSIT INSURANCE CLAIM FORM

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

PBM

Please fill this form in **Block Letters** and **Tick the Boxes** where appropriate and do not leave any column unanswered. If any detail or information is not readily available, please do not delay despatch of this report and such particulars may be sent later.

Policy Number:

Claim Number:

Period of Insurance: to

A. DETAILS OF INSURED/S

Name:

Address:

Pin code:

Telephone No:

E-mail Address:

Financial Interest:

Address of Financer:

Pin code:

If Insured is not the sole owner, for the nature of his / their interest in the property and the details of other Interests, a separate sheet may be enclosed.

B. LOSS DETAILS

Time and Date of loss: (Hrs.)

The Location/Place where loss occurred:

Who noticed the loss & when

Please attach a statement of the person.

Details of the circumstances leading to loss and cause:

Please attach separate sheet, if necessary.

The amount of loss occurred:

The denomination of currency lost:

The total amount being carried at the time of the incident:

Please attach separate sheet, if necessary

C. LOSS INTIMATION

Whether loss has been intimated to

Police Authorities Yes No

If yes, please attach the copies of the reports.

D. PREVIOUS LOSS HISTORY, IF ANY

E. DETAILS OF OTHER INSURANCES ON AFFECTED PROPERTY

F. IN YOUR OPINION, IS ANY THIRD PARTY RESPONSIBLE FOR THE LOSS

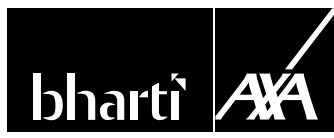
If yes name and address of such person _____

I/We hereby declare that the above questions have been conscientiously and faithfully answered and would be liable for the correctness and completeness of the statement. I/We shall provide any additional information, if needed.

Date: _____

Place: _____

Signature of Insured



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