

Claim Form

 Toll Free Number
1800-209-5846 (1800-209-LTIN)

 Website
www.ltinsurance.com

 SMS
'LTI' to 5607058 (56070LT)

GUIDELINES TO FILL THE FORM

1. Please fill the form in BLOCK LETTERS. All details with* are mandatory.
2. Please answer all the questions completely. If a particular question is not applicable to you and/or your business please mark that question as not applicable "N/A".
3. Kindly contact the Company's Office or Agent for any doubts or clarifications on the claim form.

Claim No:

Period of Insurance: To

Policy No/Cover Note No:

POLICY HOLDER INFORMATION (Please enter details of the Insured)

Title* (Pls. Tick): Ms. Mrs. Mr.

Name*:

Correspondence Address

Block/Flat No.*: Floor No.: Building Name*:

Street Name*: Locality:

Landmark*:

City/Village*: Pincode*:

Post Office:

Mobile No.*: Landline*:

Fax No.:

Email ID 1*:

Email ID 2:

BANK DETAILS (Required for Electronic Fund Transfer)

Bank Name:

Branch: Location:

Account No: Account Type:

MICR Code: IFSC Code:

VEHICLE INFORMATION (Please provide identification details of your vehicle)

Registration No.: Make*:

Model: Registration Date:

Engine No: Chassis No:

Financers:

DETAILS OF ACCIDENT

Date: Time: Place:

Name of Police Station: FIR No.:

Name of Garage: (Vehicle dismantling & repair should not start before assessment of loss by assessor)

my:asset

Private Car Package Policy

my:asset

Two Wheelers Package Policy

my:jeevika

Commercial & Miscellaneous
Vehicles Package Policy

Estimate of Loss: Rs.

Garage Phone No:

No. of persons travelling in the vehicle at the time of accident:

Please narrate the accident (please attach additional sheet/s if required):
.....
.....
.....

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

DRIVER DETAILS

Name of Driver:

Date of Birth: Licensing Authority: License No:

License Valid Upto: Type of Vehicle authorized to Drive:

Is the Driver (please tick): Owner Paid Driver Any other person (please specify).....

DETAILS REQUIRED FOR COMMERCIAL VEHICLES

Registered load carrying capacity: Load carried at the time of Accident:

G R Date and No: G R Issued by:

Authorized Passenger Capacity: No. of Passengers at the time of accident:

Permit No.: Permit Issuing Authority:

Permit Valid up to: Permit Valid For (Area):

Permit Issuance Date: Fitness Granting Authority:

Date of Last Fitness Exam: Fitness Valid Up to:

IF THERE IS A THIRD PARTY (TP) DAMAGE OR INJURY

Type of TP Loss	Injury/Death/Property Damage	Status of Victim	Passenger/Driver/Third Person

INFORMATION REQUIRED FOR THEFT BURGLARY CLAIMS

Place of Theft: Time Noticed: Date of Theft:

Police Station: FIR No:

DETAILS OF ANY OTHER INSURANCE COVERING THIS VEHICLE

Name of Insurance Company:

Insurance Policy No.: Period of Insurance: To

DECLARATION

I/We hereby declare that the details given above are true and correct to the best of my/our belief and knowledge. In the event above information or any part thereof is found incorrect, I/We agree that all rights under the policy shall forfeit.

I/We authorize L&T General Insurance Company Limited to share my/our contact information like name, company name, address, phone number and e-mail id etc. relating to me / us, with their affiliate/group companies and also for communicating any promotional marketing offers and other transactional / features / products / services of L&T General Insurance Company Limited and its affiliate group companies via SMS Telephone

Place:

Date:

Signature of Insured