NEW INDIA ASSURANCE

NEW INDIA

Assurance - When you need it most

Registered Office:
P.O. Box 884;
The New India Assurance Building,
6A Victoria Avenue,
Port of Spain, Trinidad & Tobago, W.I.
Phones: 623-1326 / 1868
625-0669 / 6522
Fax: 625-0670
e-mail: hoffice@newindiatt.com

THIRD PARTY MOTOR CLAIM FORM

CLAIM NO.: .....

Answer all questions FULLY. It will avoid unnecessary correspondence and consequent delay in the settlement of Claim.

Name of Insured: _____

Name of Driver: _____

Vehicle Registration Number: _____

Date of Accident: _____ Time: _____

Place Accident Occurred: _____

Accident Reported to: _____ Police Station: _____

Damages of Insured Vehicle: _____

THIRD PARTY PARTICULARS

Third Party's Name: _____

Third Party's Address: _____

Telephone No.: _____ Email: _____

Name of Driver: _____

Vehicle Registration Number: _____

Insurance Company: _____ Type of Cover: _____ Policy No.: _____

Place where vehicle can be inspected: _____

Damage done to Third Party's Vehicle: _____

DESCRIBE FULLY HOW THE ACCIDENT HAPPENED

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

D.P.#: _____

Date of Issue: _____

Expiry Date: _____

Class: _____

_____
Signature

SEE OVERLEAF...

GIVE FULL DETAILS OF **ALL** PERSONAL INJURIES:

NAMES	ADDRESSES & CONTACTS

SKETCH PLAN

Please show road measurements and the positions of the parties and the course taken by them leading up to the accident.

I/We the above named, do hereby, to the best of my/our knowledge and belief, warrant the truth of the foregoing statements in every respect and I/we agree that if I/we have made, or in any further declaration of the Company require in respect of the said accident, shall make any false or fraudulent statements or any suppression or concealment the Policy shall be void and all rights to recover thereunder in respect of past or further accident shall be forfeited.

Witness: Signature:

Date: Date: