

CLAIM FORM

PORTS AND TERMINALS OPERATOR'S LIABILITY

The issue of this form is not to be taken as an admission of liability or the waiver of any terms, conditions or exclusions of the Policy. The Underwriters must be notified immediately as loss or damage has become known, without delay.

Please complete and return this form to the Underwriters at the earliest. If any details are unavailable, they may be sent later, after the submission of this form. (If space here is found insufficient, please attach a separate sheet).

Policy Number:

I. INSURED'S DETAILS:

1. Name: _____

2. Address: _____

- City: _____ Pin Code: _____
3. Contact Person: _____
4. Contact Number: _____
5. Policy Period: From _____ To _____
6. Limits of Indemnity: _____
7. Please provide details of the claimant

II. PARTICULARS OF CLAIM INCIDENT:

1. Date and time of occurrence: _____
2. Place of incident: _____
3. Brief description of the kind and history of the occurrence: _____

4. When did you first come to know of the accident? _____
5. When was the accident reported to you? _____
6. When was the claim first notified to the Underwriters? _____

III. PARTICULARS OF CONSEQUENCE OF THE ACCIDENT:

1. Where can the loss be surveyed / inspected?

Contact: Name _____ Phone Number _____

2. Has any person sustained any injuries in the accident? Yes No

If yes, please give the following information:

Sl. No.	Name	Address & Contact Number	Occupation	Location at the time of incident

Has/Have the injured person(s) been medically attended? Yes No

If yes, please give details. _____

3. Has the accident caused damage to property? Yes No

If yes, please give the following information:

Sl. No.	Name of the owner(s) of the property	Address & Contact Number	Description of the property	Nature and extent of damage

4. Has any claim been made upon you by any person? Yes No

If yes you must provide us with the details including your reply, if any.

State by whom and give full particulars. _____

(Attach a copy of the notification received and of the bill, if submitted)

5. Estimated amount of Claim _____

6. Give, if possible, the names of all witnesses to the accident. (Use additional sheet if required)

Sl. No.	Name of the witness	Address	Contact Number

7. Has the accident been reported to any authority? Yes No

If yes, mention to whom and attach a copy of the report submitted. _____

8. What action, if any, has been taken by the authority? _____

9. Give details of statute/law under which in your opinion, liability may arise. _____



RAHEJA QBE GENERAL INSURANCE CO. LTD.

IV. DETAILS OF OTHER INSURANCES

Give details of other insurances, if any, covering the current loss. _____

PLEASE GIVE ALL OTHER INFORMATION RELEVANT TO THIS CLAIM _____

I/We, the above named, do hereby, to the best of my/our knowledge and belief, warrant the truth and completeness of the foregoing statements in every respect; and I/we agree that if I/we have made, or will make any false or fraudulent statement, or suppress or conceal any relevant or matter with regard to the claim, or if our claim is dishonest or fraudulent or is supported by any dishonest or fraudulent means or devices by us or anyone acting on our behalf or with our knowledge, our claim shall be absolutely forfeited and the Policy shall be null and void.

Date :

Place :

Signature of the Claimant