

CLAIM FORM FOR CATTLE INSURANCE POLICY

(The issue of this form is not to be taken as an Admission of Liability)

Office Address:	Cover Note / Policy No. : Period of Insurance : Date of Death : Claim Number :
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Please Answer all Questions Completely

SECTION 1

a) Details of Owner of Insured Cattle	
1 Name	
2 Address for correspondence	
3 Contact Number	
4 Aadhar No. (Copy Mandatory)	
5 PAN No. (Copy Mandatory)	
b) Details of the animal Insured	
1 Tag /RFID Number of Insured Cattle	
2 Breed of Cattle	
3 Age of Cattle	
4 Colour of Cattle	
5 Identification Marks	

1. **Type of claim:** Death

2. **In Case of Death:**

- **Reasons for Death:** _____
- **Details for Accidental Death:** _____
Place, Date and Time of Accident: _____
Details of Accident: Attach separate sheet
Whether Reported to Police: [Yes / No], if yes Time of Report: _____
Date and Time of Death: _____
- **Details for Other Disease Related Death:** _____
Time of Disease: _____
Treatment Given: Attach separate sheet
Details of the Doctor Contacted: _____
Date and Time of Disease Incidence: _____

3. **In case of Permanent Total Disablement**

- a) Type of disablement: _____
- b) Reason for disablement: _____
- c) Medical Treatment given: _____

I hereby agree, affirm and declare that:

- (a) The statements/information given/stated by me in this claim form are true, correct, and complete.
- (b) No material information which is relevant to the processing of the claim or which in any manner has a bearing on the claim has been

withheld or not disclosed.

- (c) If I have given/made any false or fraudulent statement/information or suppressed or concealed or in any manner failed to disclose material information, the policy shall be void and that I shall not be entitled to all/any rights to recover there under in respect of any or all claims, past, present, or future.
- (d) The receipt of this claim form/other supporting/related documents does not constitute or be deemed to constitute an agreement by the Company of the claim and the Company reserves the right to process or reject or require further/additional information in respect of the claim.
- (e) I/We hereby give my/our consent to the Company to verify and obtain my/our identity/address proof as well as the identity/address proof of the insured through Central KYC Registry or UIDAI or through any other modes for the purpose of undertaking KYC.

Place: _____

Date: |D|D_|/|M|M|/|Y_|Y_|Y_|Y_|

_____ Thumb imprint/Signature of the Cattle Owner

Documents required to be submitted:

- i. Duly completed claimform
- ii. Identification tags of Insured Animal
- iii. Postmortem Report from veterinary doctor containing the name of disease & reason for death
- iv. Three photographs of minimum 6" X 4" size of the Insured Animal. Photograph must be such that Identification tag number should be clearly visible in one, one for whole body of animal with tag being visible & one photograph should be of farmer along with dead animal. Group photograph shall not be admitted for registration of claim
- v. In case of death due to any disease (if specifically covered under the Policy) all the papers in connection with the Treatment, Diagnosis & Vaccination record received from a Veterinary doctor
- vi. In case of death due to Vehicular accident, FIR, Spot Panchnama, Closing Report from the Police.
- vii. Certificate of insurance /policy copy in original.

SECTION II (TO BE COMPLETED BY AUTHORISED VETERINARY)

1. Name and address of the authorized Veterinary doctor	
2. In case of death, date of admission of dead cattle	
3. Date of medical examination of dead cattle	
4. (i) Reason of death	
(ii) Particulars of medical examination conducted	
(iii) Remarks and comments	
(iv) Treatment Given	Yes / No, If yes provide in attached format.
5. Market value of the insured Cattle prior to insured event (INR)	

I hereby certify that the above mentioned animal belonging to Shri/Smt. _____ of village _____ died on _____ due to accident/disease as confirmed by Postmortem and Observation of carcass.

Date: |D|D_|/|M|M|/|Y_|Y_|Y_|Y_|

Signature of Vet. Doctor:

Name:

Qualification:

Registration No.:

Address: