

HORSE INSURANCE

Claim Form

Please note that the issue of this claim form is not to be taken as an admission of liability

| | |
|---------------------------------------|---|
| Insurance Policy Number | |
| Period of Insurance | From To |
| A. DETAILS OF INSURED CLAIMANT | |
| 1 Name Of Insured/Claimant | |
| 2 Address | City: State: Pin Code: |
| 3 Contact | Phone Number: Mobile Number: E-mail: |

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DESCRIPTION OF ANIMAL CLAIMED FOR

| Type of Animal | EarTag | Breed Number | Sex | Detailed Description Of Animal Like Colour, body Marks, Other Distinct Features | Age | Value prior to illness/Death |
|----------------|--------|--------------|-----|---|-----|------------------------------|
| | | | | | | |

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|---|--|
| 1. When was the animal first seen ill? | |
| 2. When was notice sent to Veterinary Doctor? | |
| 3. When first and last seen by Veterinary Doctor? | |
| 4. Name and address of Veterinary Doctor Who attended | |
| 5. Place of death, with date and hour. | |
| 6. If from Disease, how do you account for it? If from Accident, how did occur and who was In charge? If operated upon recently, state nature & date, also name of Surgeon. | |
| 7. Purpose for which used or employed before Death. | |
| 8. Did you breed or buy the Animal? | |

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| 9. Date of last calving. | |
| 10. If bought, State: - a) From Whom? b) Date of purchase c) Price Paid | a) b) c) |
| 11. Amount of claim Amount of salvage (attach voucher) | , |
| 12. Is the animal insured elsewhere? Are you receiving compensation from any other source? If so, from whom. | |
| 13. a) If animal has not died, describe the nature of injury/disease & state when it occurred & its duration | |
| b) Has this injury/disease resulted in permanent incapacity conceive or yield milk or loss of use for the purpose of which the animal is kept ? c) What steps were taken by you after the injury/disease was noticed to prevent the Permanent incapacity to conceive or yield milk or loss of use for the purpose of which the animal is kept ? | |

DECLARATION

I/We agree to provide additional information to the company, if required. I/We the above mentioned, do hereby, to the best of my/our knowledge and belief, warrant the truth of the foregoing statement in every respect, and if I/We have made, or in any further declaration the company may require in respect of the said accident, shall make any false or fraudulent statement, or any suppression or concealment, the policy shall be void and all rights to recover there under in respect of past or future accident shall be forfeited.

Date: _____

Place: _____
Insured/Claimant

Signature of

Generali Central Insurance Company Limited (Formerly known as Future Generali India Insurance Company Limited) | Registered Office: Unit No. 801 & 802, 8th Floor, Tower C, Embassy 247 Park, LBS Marg, Vikhroli (West), Mumbai – 400083 | **IRDAI Regn. No.:** 132 | **CIN:** U66030MH2006PLC165287 | **Website:** <https://generalicentralinsurance.com> | **Email ID:** gccicare@generalicentral.com | **Toll-free Phone:** 1800 220 233 / 1860 500 3333/ 022 6783 7800