



MONEY INSURANCE CLAIM FORM
ACCIDENT DEPARTMENT

Date _____ 20

PARTICULARS OF POLICY

1. Insured _____
2. Address _____
_____ Tel. No. _____
3. Policy No. & Period _____ From _____ To _____
4. Estimated amount in Transit Limit of Liability _____ Limited per Single Carry Rs. _____

CIRCUMSTANCES AND SITUATION OF LOSS

5. How did loss occur : Date / Hour _____ Date _____ Time _____
6. Where did loss occur _____
7. The money in transit / & Amount of Loss Rs. _____ Rs. _____
8. MONEY in the premises of the insured while such premises are open for business _____
9. Money secured in locked safe at the premises as above other than
Cash-in-Transit on the day of collection Rs. _____
10. Mode and manner of carrying money _____
11. Full Particulars of Loss and details of Safety Precautions taken _____

12. Where there any witnesses to the loss _____

PARTICULARS OF EMPLOYEE

13. Name of Employee involved _____
14. For how long the employee is in your service _____
15. What is his present remuneration _____
16. What action did your employee taken of (i) Bank Assistance _____ ii) Inform the Police _____
17. Do you have any Deposit or Cash Guarantee in respect of your Employee ? _____
18. If the loss has arisen due to wilful negligence of the employees, _____
what disciplinary action has been taken against them ? _____
19. What action is being taken by the police ? _____

We do hereby affirm and declare that the above statements of facts are in all respect true and complete to the best of our knowledge and belief as we claim in respect thereof.

Supplied on _____

Checked / Recorded by _____

Claim No. _____

Signature of Claimant _____
(with Rubber Stamp)