CLAIM FORM

GRIHA RAKSHA PLUS

SBI general INSURANCE
SURAKSHA AUR BHAROSA DONO

ISSUE OF THIS CLAIM FORM IS NOT TO BE TAKEN AS AN ADMISSION OF LIABILITY

(To be filled in block letters)

- If any detail or information Is not readily available please do not delay the dispatch of this form and such particulars may be sent later

Policy No:

Period of Insurance to

Claim Number:

A. DETAILS OF INSURED/CLAIMANT

Name as per policy:

Address:

City: State:

Pin Code: Phone No:

E-mail ID:

Brief Description of Business / Office/Industry/Occupation

Limits of Indemnity under the Policy (Rs.)

B. DETAILS OF LOSS/ACCIDENT

Date of Loss D D M M Y Y Y Y Time of Loss A.M. / P.M.

Loss Location

Address

City: State:

Pin Code: Phone No:

Contact Details of person/s at Loss Location

Name

Relationship with Insured

Phone Number : Mobile Number :

E-mail ID:

Describe Cause of Loss/Damage

Estimated Loss (Rs.)

(a) Building (c) FFF (e) Others1

(b) P&M (d) Stocks (f) Others2

WITNESS DETAILS

Were there any witnesses to the loss / accident? Yes ☐ No ☐ If 'Yes'

Name of Person/s

Address

City: State: Pin Code:

Phone No: Mobile Number:

E-mail ID:

INFORMATION TO AUTHORITY

Has the loss been reported to an Authority Yes ☐ No ☐

If 'No', reason for not reporting

If "Yes", provide details

☐ Fire ☐ Police ☐ Municipality ☐ Other

Name of Authority

Information Report No./Authority Reference No. and Date

Contact Person/s

Address

City: State: Pin Code:

Phone No: Mobile Number:

E-mail ID:

C. DETAILS OF OTHER INSURANCE

Is the loss/damage covered under any other Insurance

Yes ☐ No ☐ If 'Yes', specify details and attach a copy of the policy

Name of Insurer:

Address

City: State: Pin Code:

Phone No: Mobile Number:

E-mail ID:

Policy No: Period of Insurance: to

Sum Insured (Rs.)

D. DETAILS OF OTHER INTEREST

Is the Insured the Sole Owner of the property?

Yes No If 'No', specify

Name of Insurer:

Person/s who has/have interest on property

Address

City: State: Pin Code:

Phone No: Mobile Number:

E-mail ID:

E. DETAILS OF PREVIOUS LOSSES

Losses during the 3 preceding years

Date of Loss	Claim Description and Cause of Loss	Value of Loss (Rs.)	Insurer

F. DETAILS OF OTHER INFORMATION

Do you wish to provide any other information?

Yes No If 'Yes', specify

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 make in any further declaration, the Company may require in respect of the said accident, any false or fraudulent statement, or any suppression or concealment, my/our claim shall be absolutely forfeited, and the Policy shall be null and void, and all rights to recover there under in respect of past or future loss/accident shall be forfeited.

Date: D D M M Y Y Y Y

Place

Name of Insured/Claimant

Signature of Insured/Claimant