(A joint venture between of State Bank of India and Insurance Australia Group)

Corporate Office: Fulcrum Building, 9th Floor, A & B Wing, Sahar Road, Andheri (East), Mumbai 400 099.

CLAIM FORM

Please tick the appropriate check box

Public Liability Act ☐	Public Liability ☐	Commercial General Liability ☐	Product Liability ☐

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

Policy Number______________________________Period of Insurance __________to ______________

Claim Number______________________________Retroactive date, if any: _______________________

A. DETAILS OF INSURED/CLAIMANT:

Name of the Insured : ____

______________________________ Address______________________________

____

______________________________ City_____________________________State

Trade or Business _ Date of Last Premium Paid _

Limits of Indemnity under the policy _

B. DETAILS OF LOSS:

Date of Loss______/_____/_________ Time of Loss_________A.M. / P.M.

How did accident / incident occur? Give full details and description on back of form illustrated by rough sketch if necessary :____

Place Accident Occurred with full address details :____
____

Is the cause of accident attributable to negligence of any of your employee/s ☐(Yes) ☐(No), If 'Yes',

Occupation____________________Name___________________Address ______________________________

Is the cause of accident attributable to any person NOT in your employ ☐(Yes) ☐(No), If 'Yes',

Occupation____________________Name___________________Address ______________________________

Is the cause of accident attributable to work being carried out under contract, ☐ (Yes) ☐ (No), If 'Yes',

Has any indemnity or disclaim been given or received, pl. provide details ______________________________
____

Detail act of negligence :____

Is the cause of accident attributable to any defect in your ways, works, machinery, plant or premises?

☐ (Yes) ☐(No), If 'Yes', Please state exact nature of defect

WITNESS DETAILS	INFORMATION TO STATUTORY AUTHORITY
Were there any witnesses to the loss / accident? ☐ (Yes) ☐ (No), If 'Yes', Name of Person/s ____ Address ____ ____ City ____ Sta te ____ Pin Code ____ Phone Number ____ Mobile Number ____ Email ID ____	Has the loss been reported to an Authority ☐ (Yes) ☐ (No), Name of Authority ____ Authority Reference No. ____ Contact Person/s ____ Address ____ ____ City ____ State ____ Pin Code ____ Phone Number ____ Mobile Number ____ Email ID ____

C. DETAILS OF OTHER INSURANCE/INTEREST

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 ____ Policy

No. ____ Period of Insurance ____ to ____

Sum Insured (Rs.) ____

D. THE INJURED / DECEASED PERSON *

Name and address of Injured/deceased : ____

Gender: ☐ (Male) ☐ (Female), Age: ____

Address ____ City

____ State ____ PinCode ____ Phone

Number ____ Mobile Number ____

State occupation / nature of work of the injured person ____

Was the Injured/deceased person engaged in this occupation when the accident occurred? ____

____

Is the Injured/deceased person in your direct employment? ☐ (Yes) ☐ (No),

Any Relationship between you and the injured ? ____

Have the Injured/deceased persons been taken to hospital or medically attended? ☐ (Yes) ☐ (No),

If "Yes", specify Name of Hospital / Physician ______________________________

Date of Admission_/___/_______Date of Discharge__/___/_______

State nature of injury & part of body affected ______________________________

Is there disablement? (Yes) ☐ (No) ☐

If "Yes" select Total ☐ ☐ Partial ☐ Permanent ☐ Temporary

Is the disability solely caused by this accident / Incident (Yes) ☐ (No) ☐,

If "No", give details ______________________________

How long is the disablement expected to last? ______Days Upto___/____/_________

Extent of disability________________%

Was the injured person under the influence of alcohol or drugs at the time of accident? ☐ (Yes) ☐ (No),

Present health condition ______________________________

In event of Death: Post Mortem Done (Yes) ☐ (No) ☐, Date of PM Done___/___/_________PM No. ________________ Name and address of Hospital where Post mortem has been done ______________

* In the event of more than one person being injured/dead, please provide the indiividual detials as detailed above in a separate annexure

E. DAMAGE DETAILS

Name and address of the owner of damaged property ______________________________

Nature and extent of damaged property ______________________________

Estimated Cost of Repair

F. PRODUCT DETAILS (To be filled, in case of claim under Product Liability)

Describe the Product involved including its standards and specifications :

Was the product Sold, Supplied, Manufactured by you?

When was the product put into circulation (Date)

Identification of the defective lot of product involved :_

Is the defective product caused by some defective raw material or parts provided by independent supplier(s) or contractor(s)? (Yes) (No), If 'Yes', please specify details and identity (ies) of those party (ies)?

a. Please specify the defective parts of the product concerned and confirm whether any testing has been carried out to indentify the problem, ? (Yes) (No), If 'Yes', please provide us with a copy of the internal/external testing report, if available.

b. When and from whom was the product purchased by the injured / damaged party?

c. Have you Inspected the Product? (Yes) (No)

Have you notified all other parties who may have an interest in the product? (Yes) (No)

Has any communication, verbal or written been made to you or on behalf of any injured person or owner of damaged property, (Yes) (No) if yes, please give particulars :

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: Insured's Signature with Company Seal
Place: