SBI general INSURANCE
SURAKSHA AUR BHAROSA DONO

CLAIM FORM
MOTOR - COMPULSORY PERSONAL ACCIDENT (Owner-Driver) INSURANCE

Issuance of this form does not amount to admission of any liability or a waiver of any of the terms and conditions of the insurance contract. If any claim is in any manner dishonest or fraudulent or is supported by any dishonest or fraudulent means or devices, whether by You or any Insured Person or anyone acting on behalf of You or an Insured Person, then this Policy shall be void and all benefits paid under it shall be forfeited.

Policy Number _____Period of Insurance from_____ to _____

Claim Number_____

A. DETAILS OF INSURED/CLAIMANT:

Name of the Claimant: _____

Name of the Insured : _____

Relationship with Insured: _____Designation (If applicable): _____

Date of Birth: _____/_____/_____ ☐ Male ☐ Female

Address _____

City_____State_____Pin Code_____

Phone Number : _____ Mobile Number_____

Email ID :_____

Date of Accident / Incidence _____/_____/_____ Time of Loss _____A.M. / P.M.

Cause of Accident / Incidence : _____

Details of Accident/ Incidence : _____

Registration number of the vehicle_____ Chassis no of the vehicle_____

Accident/ Incidence Location Address :_____

City_____State_____Pin Code_____

Phone Number : _____Mobile Number _____
Email ID_____
Were there any witness to the Accident/ Incidence ☐(Yes) ☐(No), If 'Yes',
Name of Witness : _____

Address of Witness :_____

City_____State_____Pin Code_____

Phone Number : _____ Mobile Number _____
Email ID_____

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Is relative of claimant ☐(Yes) ☐(No)

B. INFORMATION TO AUTHORITY

Has the loss been reported to an Authority ☐ (Yes) ☐(No),

If 'No', reason for not reporting_____

If "Yes", provide details ☐Police ☐Other

Name of Authority: _____

First Information Report _____

MLC No: _____

Report Date: _____

Name of Person: _____

Address : _____

City_____ District _____ State _____Pin Code_____

Phone Number : _____ Mobile Number _____

Email ID_____

Was the person moved to hospital immediately after the accident? ☐ (Yes) ☐(No), If 'Yes',

Name of Hospital : _____

Address of Hospital : _____
City_____State_____Pin Code_____

Phone Number : _____Mobile Number_____ Email ID_____

Date of Admission : _____/_____/_____ Date of Discharge: _____/_____/_____

C. DETAILS OF OTHER INSURANCE/INTEREST

Is the Accident/ Incidence covered under any other Insurance ☐ (Yes) ☐(No), If 'Yes', specify details and attach a copy of the policy

Name of Insurer: _____

Policy Issuance office Location:
_____

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Policy No _____Period of Insurance

_____to_____ Sum Insured Rs.)_____

If yes please specify _____

D. ANY OTHER INFORMATION YOU MAY WISH TO PROVIDE

_____

_____

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.

Place_____ Signature _____

Date_____ Name of Insured/Claimant_____

Annexure I: TO BE COMPLETED BY NOMINEE IN THE EVENT OF INSURED'S DEATH

Name of Nominee_____

Relationship with Insured: _____Date of Birth_____

Address _____

Contact Details

Phone Number _____Mobile Number_____

Email ID _____

∗ If nominee is minor, kindly provide the Appointee details

Name of Appointee _____

Relationship with Nominee _____Date of Birth_____

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Address _____

Contact Details
Phone Number _____Mobile Number_____

Email ID _____

I/We hereby declare and warrant the truth of the foregoing particulars in every respect. I /We agree that if I/We have made or shall make false or untrue statement, suppression or concealment, my/our right to compensation shall be forfeited.
I/We also hereby declare that I am/we are accepting the amount in full discharge of your obligations under the policy to the Insured Person and /or his/her legal heirs. I/we will hold you indemnified in the event of any claim under this policy being made against you by any other person or persons.

Place_____ Signature _____

Date_____ Name of nominee _____

Annexure II: MEDICAL CERTIFICATE: To be filled by Treating Doctor

Name and address of Injured:
_____

Gender: ☐ (Male) ☐(Female), Date of birth / Age:
_____

Nature of the Accident /Incident and Details of Injuries Sustained:
_____

_____

Cause of accident/ Incident:
_____

Are the injuries: A) Soley due to accident /incident: ☐ (Yes) ☐(No),

B) Tracebale to any Disease : ☐ (Yes) ☐(No), If 'Yes ',

Give details _____

C)Traceable to any previous injury: ☐ (Yes) ☐(No), If 'Yes ',

Give details _____

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Was insured under influence of drugs / intoxicants at the time of accident: ☐ (Yes) ☐(No),

Is the injured person suffering from any disease or injury which may have contributed to the accident or likely to aggravate his /her condition or delay improvement: ☐ (Yes) ☐(No), If 'Yes ',

Give details _____

_____Details of Disablement: _____

_____

Nature of Disablement:

Permanent Total Disablement: ☐ (Yes) ☐(No)

Please specify the percentage_____

Details of Treatment given:

_____

_____

I certify that I have examined the above named Insured. Tthe above statements are correct and that the injured person is necessarily disabled by the accident referred to. I understand that any person who knowingly and with intent to defraud or deceive any insurance company files a claim containing any materially false, incomplete or misleading information may be subject to prosecution for insurance fraud.

Name of treating Doctor : _____

Qualifications: _____ Registration No: _____

Signature of the Doctor: _____ Date: _____/_____/_____

Address: _____

Phone No.: _____E-mail: _____

Signature of the Doctor: _____

ENCLOSURES CHECKLIST1.Accidental Death:

- ☐ Claim form duly filled & signed by claimant
- ☐ Policy copy, vehicle registration certificate & driving license of insured
- ☐ Claim Intimation
- ☐ FIR / MLC Copy /Spot Panchnama / Inquest Panchnama
- ☐ Death Certificate

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- ☐ Post Mortem Report (If conducted)
- ☐ Final Police Report Affidavit from the legal heirs of the deceased (in case nomination has not been filed by deceased)
- ☐ CKYC form duly filled & signed by beneficiary
- ☐ CKYC documents (Copy of PAN & Aadhar card) of beneficiary
- ☐ For NEFT payment, NEFT details of beneficiary (copy of bank passbook/cancelled cheque)

2. Permanent Total Disablement

- ☐ Claim form duly signed
- ☐ Policy copy, vehicle registration certificate & driving license of insured
- ☐ Claim Intimation
- ☐ FIR / MLC Copy /Spot Panchnama
- ☐ Hospital treatment records, consultation papers, discharge summary and Investigation reports
- ☐ Medical certificate
- ☐ Nominee certificate
- ☐ Disability Certificate
- ☐ Photograph of the injured with reflecting disablement
- ☐ CKYC form duly filled & signed by beneficiary
- ☐ CKYC documents (Copy of PAN & Aadhar card) of beneficiary
- ☐ For NEFT payment, NEFT details of beneficiary (copy of bank passbook/cancelled cheque)

Details of Any Other related document: