



SURAKSHA AUR BHAROSA DONO

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

Corporate & Registered Office: 'Natraj', 301, Junction of Western Express Highway & Andheri - Kurla Road, Andheri (East), Mumbai - 400 069.

ALL RISK INSURANCE CLAIM FORM

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

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 Number _____ Period of Insurance _____ to _____

Claim Number _____

A. DETAILS OF INSURED/CLAIMANT

Name as per policy	_____
Address	_____ _____
City	_____ State _____ Pin Code _____
Contact Details	Phone Number _____ Mobile Number _____ Email ID _____
Brief Description of Business /Office/Industry/Occupation	_____ _____

B. DETAILS OF LOSS/ACCIDENT

Date of Loss	___/___/___	Time of Loss	_____ A.M. / P.M.
Loss Location	_____		
Address	_____ _____		
	City _____	State _____	Pin Code _____
Contact Details of person/s at Loss Location	_____		
Name	_____		
Relationship with Insured	_____		
Phone Number	_____	Mobile Number	_____
	Email ID _____		
Describe Cause of Loss/Damage	_____ _____		
Estimated Loss (Rs.)	_____		

WITNESS DETAILS	INFORMATION TO AUTHORITY
<p>Were there any witnesses to the loss / accident? <input type="checkbox"/> (Yes) <input type="checkbox"/> (No), If 'Yes', Name of Person/s _____ Address _____ City _____ State _____ Pin Code _____ Phone Number _____ Mobile Number _____ Email ID _____</p>	<p>Has the loss been reported to an Authority <input type="checkbox"/> (Yes) <input type="checkbox"/> (No), If 'No', reason for not reporting _____ If "Yes", provide details <input type="checkbox"/> Fire <input type="checkbox"/> Police <input type="checkbox"/> Municipality <input type="checkbox"/> Other Name of Authority _____ Information Report No./Authority Reference No. and Date _____ Contact Person/s _____ Address _____ City _____ State _____ Pin Code _____ Phone Number _____ Mobile Number _____ Email ID _____</p>

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 _____ PinCode _____

Phone Number _____ MobileNumber _____ EmailID _____

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

Nature of Interest _____

Person/s who has/have interest on property _____

Address _____

City _____ State _____ PinCode _____

Phone Number _____ MobileNumber _____ EmailID _____

E. DETAILS OF ITEMS AFFECTED

Sl. No.	Description of Equipment	Manufacturer	Year of Manufacture	Identification/ Machine/Serial No.	Sum Insured (Rs.)	Date of Last Maintenance	Date of Expiry of AMC/Warranty	Cost of Repair/Replacement (Rs.)

Has the affected equipment undergone any repairs previously?
If "Yes", the nature of such repairs

(Yes) (No)

Date of Repair	Nature of Repair	Parts affected	Cost of Repair(Rs.)

F. DETAILS OF REPAIR/REPAIRER

Is the repair being carried out in house?

(Yes) (No),

If 'Yes', specify and submit Job-Work estimates along with Pro-forma Invoices of Spare Parts to be replaced

If " No" specify following details

Name of the Repairer _____

Name of contact person/s _____

Address _____

City _____ State _____ PinCode _____

Phone Number _____ MobileNumber _____ EmailID _____

G. DETAILS OF PREVIOUS LOSSES

Losses during the 3 preceding years

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

H. 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.

Place _____

Signature _____

Date _____

Name of Insured/Claimant _____