SURAKSHA AUR BHAROSA DONO

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

SIGN BOARD INSURANCE POLICY
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

_____

Limits of Indemnity under the Policy (Rs.)_____

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
Were there any witnesses to the loss / accident? ☐(Yes) ☐(No), If 'Yes', Name of Person/s_____ _____ Address _____ _____ City_____ State_____ Pin Code_____ Phone Number _____ Mobile Number_____ __ Email ID _____	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 Number _____ Mobile Number_____ __ Email 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_____PinCode_____

Phone Number _____MobileNumber_____EmailID_____

Policy No._____ Period of Insurance _____to_____

Sum Insured (Rs.)_____

D. DETAILS OF OTHER INFORMATION

Do you wish to provide any other information? ☐(Yes) ☐(No), If 'Yes', specify

_____

_____

_____

SECTION II – THIRD PARTY LIABILITY

A. DETAILS OF LOSS/ACCIDENT

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

Loss Location

Address _____

_____

City_____State_____Pin Code_____

1. Details of Claimant

Full name of the claimant or potential claimant (i.e. the party making the claim or potential claim upon the Insured).
Address of the claimant.

2. Details of Claim or Circumstance

What is the precise nature of the claim (i.e. the claimant's allegations) or the fact or circumstance that might give rise to a claim?
Have proceedings been commenced? If so, please attach a copy of the court documents.
On what date did you first become aware of the claim or of the fact or circumstance?
On what date was the claim or the intimation of a claim first made to you?
Was the first intimation of a claim oral or in writing? If in writing please attach a copy. If oral, please give a "first person" account of the conversation, (i.e. "I said", "He said").
What amount, if any, is claimed? If known, what does that amount comprise?

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 loss/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_____