SBI General Insurance Company Limited
IRDA Reg. No. 144 dated 15/12/2009 | CIN: U66000MH2009PLC190546

SBI general INSURANCE
SURAKSHA AUR BHAROSA DONO

Call (Toll Free)
1800 22 1111 | 1800 102 1111
www.sbigeneral.in

INDIVIDUAL PERSONAL ACCIDENT INSURANCE POLICY

Claim Form

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 the Insured Person/Claimant or anyone acting on behalf of the Insured Person, then the benefits under this policy shall be void and all benefits payable under it shall be forfeited.

Policy No. Claim No.

Period of Insurance From D D M M Y Y Y Y To D D M M Y Y Y Y

A. DETAILS OF INSURED/CLAIMANT

1. Name of the Claimant — SURNAME MIDDLENAME FIRSTNAME
2. Name of the Insured — SURNAME MIDDLENAME FIRSTNAME
3. Relationship with Insured — Designation (if applicable)
4. Date of Birth of Insured D D M M Y Y Y Y — Gender ☐ Male ☐ Female — Employee No.
5. Address — Plot No/Door No. — Building Name
   Road — Area
   City — District
   State — Pincode
6. Contact Details — Phone No. — Mobile
   E-mail Id

B. DETAILS OF ACCIDENT/INCIDENCE

1. Date of Accident/Incidence D D M M Y Y Y Y — Time of Loss : A.M. / P.M.
2. Cause of Accident/Incidence
3. Details of Accident/Incidence
4. Accident/Incidence Location Address
   City — District
   State — Pincode
5. Were there any witness to the Accident/Incidence? ☐ Yes ☐ No
   If 'Yes', provide details,
   Name of Witness
   Address of Witness — Plot No/Door No. — Building Name
   Road — Area
   City — District
   State — Pincode
   Contact Details — Phone No. — Mobile
   E-mail Id
6. Is Witness relative of Claimant? ☐ Yes ☐ No

Version 1.0, Feb 2025

C.INFORMATION TO POLICE AUTHORITY

1. Has the loss been reported to Police Authority? ☐ Yes ☐ No

If 'No', reason for not reporting

First Information Report No. | Medico Legal Case (MLC) No.

Report Date D D M M Y Y Y Y

Address of Police Station
Plot No/Door No. | Building Name
Road | Area
City | District
State | Pincode

Contact Details
Phone No. | Mobile
E-mail Id

2. Was the person moved to hospital immediately after the accident? ☐ Yes ☐ No
If 'Yes',
3. Name of Hospital

Address of Hospital
Plot No/Door No. | Building Name
Road | Area
City | District
State | Pincode

Contact Details
Phone No. | Mobile
E-mail Id

4. Date of Admission D D M M Y Y Y Y | Date of Discharge D D M M Y Y Y Y

D.DETAILS OF OTHER INSURANCE

1. 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 No.

Policy Issuance Office Location | Sum Insured (Rs.)

Period of insurance From D D M M Y Y Y Y To D D M M Y Y Y Y

E.PAYEE DETAILS [Payable to Nominee (*All fields are mandatory)]

Bank Name | Bank Branch

Bank Account No. | IFSC Code

MICR No. | PAN No.

Note: It is agreed that the Policyholder/Claimant will intimate in writing to SBI General about any change in bank account details. Please attach a cancelled cheque pertaining to the same account. In case premium is issued from the same bank account through cheque, the cancelled cheque is not required.

F.FOR WHICH BENEFIT DO YOU CLAIM? [PLEASE TICK ( ) THE APPROPRIATE BOX]

Benefit	Amount claimed	Benefit	Amount claimed
☐ Accidental Death		☐ Temporary Total Disability (TTD)	
☐ Permanent Total Disability (PTD)		☐ Adaptation Allowance	
☐ Permanent Partial Disability (PPD)		☐ Education Benefit	

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G. 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.

Place

Date D D M M Y Y Y Y

Signature of Insured/Claimant

Name of Insured/Claimant

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

1. Name of Nominee — SURNAME MIDDLENAME FIRSTNAME
2. Relationship with Insured — Date of Birth D D M M Y Y Y Y Sex M F
3. Address — Plot No/Door No. — Building Name
   Road — Area
   City — District
   State — Pincode
4. Contact Details — Phone No. — Mobile
   E-mail ID

If nominee is minor, kindly provide the Legal Guardian details

5. Name of Guardian — SURNAME MIDDLENAME FIRSTNAME
6. Relationship with Insured — Date of Birth D D M M Y Y Y Y
7. Address — Plot No/Door No. — Building Name
   Road — Area
   City — District
   State — Pincode
8. Contact Details — Phone No. — Mobile
   E-mail Id

I hereby declare that the information furnished in this claim form is true and correct to the best of my knowledge and belief. If I have made any false or untrue statement, suppression or concealment of any material fact with respect to questions asked in relation to this claim, my right to claim reimbursement shall be forfeited. I also consent and authorize TPA/insurance company, to seek necessary medical information/documents from any hospital/Medical Practitioner who has attended on the person against whom this claim is made. I hereby declare that I have included all the bills/receipts for the purpose of this claim and that I will not be making any supplementary claim except the pre/post-hospitalization claims, if any (for indemnity policies only). 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

Date D D M M Y Y Y Y

Signature

Name of Nominee

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ANNEXURE II: MEDICAL CERTIFICATE - TO BE FILLED BY TREATING DOCTOR

1. Name & Address of the Insured — SURNAME | MIDDLE NAME | FIRST NAME

2. Gender ☐ Male ☐ Female — Date of Birth / Age D D M M Y Y Y Y / ☐☐

3. Nature of the Accident/Incident and details of injuries sustained _____

4. Cause of Accident/Incident _____

5. Are the injuries:
   a) Solely due to Accident/Incident ☐ Yes ☐ No
   b) Traceable to any disease ☐ Yes ☐ No
   If 'Yes', give details _____
   c) Traceable to any previous injury ☐ Yes ☐ No
   If 'Yes', give details _____

6. Was insured under influence of drugs / alcohol / intoxicants at the time of accident? ☐ Yes ☐ No

7. 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
   a) Permanent Total Disablement ☐ Yes ☐ No
   b) Permanent Partial Disablement ☐ Yes ☐ No
   c) Temporary Total Disablement ☐ Yes ☐ No

   Details of Disablement _____

   Details of treatment given _____

8. According to you, how long should the injured person be confined to bed/house as the direct and sole consequence of the injury sustained? From D D M M Y Y Y Y To D D M M Y Y Y Y

9. During this period will the injured person be able to attend to his/her normal duties? ☐ Yes ☐ No

   If 'Yes', from D D M M Y Y Y Y

   If 'No', please state probable date of his / her being able to attend to his normal duties D D M M Y Y Y Y

I certify that I have examined the above named Insured, the above statements are correct.

Name of treating Doctor

Qualifications — Registration No.

Address

Contact Details — Phone No.

E-mail Id

Signature of the Doctor _____ Date D D M M Y Y Y Y

Stamp of the Doctor _____ Stamp of the Hospital _____

H. ENCLOSURES CHECKLIST

Please attach following documents and tick appropriate box. (Please attach documents as per benefit claimed and tick appropriate box)

1. Accidental Death:

- ☐ Claim Form duly filled & signed
- ☐ Claim Intimation
- ☐ Police Copy
- ☐ Copy of FIR (First Information Report) / Spot Panchnama / Inquest Panchnama
- ☐ Death Certificate
- ☐ Death Summary
- ☐ Post Mortem Report
- ☐ Original Legal Heir Certificate (in case nomination has not been filed by deceased)

2. Permanent Total Disablement / Permanent Partial Disablement / Temporary Total Disablement:

- ☐ Claim Form duly filled & signed
- ☐ Claim Intimation
- ☐ Police Copy
- ☐ Copy of FIR (First Information Report) / Spot Panchnama / Inquest Panchnama
- ☐ Photograph of the injured with reflecting disablement
- ☐ Disability Certificate from appropriate Government Authority
- ☐ Medical Certificate from treating Doctor
- ☐ Leave Certificate from the Employer
- ☐ Investigation Reports
- ☐ Treatment Papers

3. Education Benefit:

- ☐ All documents of List – 1 or List - 2, plus
- ☐ Study Certificate from the school of the dependent child mentioning the parent's name

4. Adaptation Allowance:

- ☐ All documents of List - 2, plus
- ☐ Original Bills and payment receipt of Adaptation done
- ☐ Prescription of the doctor mentioning the indication for Adaption

Note: The Company reserves the right to seek additional documents (including KYC documents) and information as and when necessary for processing of the claim.

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