# CLAIM FORM

## SARAL SURAKSHA BIMA, SBI GENERAL INSURANCE COMPANY LIMITED

SBI general INSURANCE
SURAKSHA AUR BHAROSA DONO

**Important:**

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 D D M M Y Y Y Y to D D M M Y Y Y Y

Claim Number:

**A. Details Of Insured/Claimant:**

Name of the Claimant:

Name of the Insured:

Relationship with Insured: Designation (If applicable):

Date of Birth: D D M M Y Y Y Y Gender: Male ☐ Female ☐ Others ☐

Address:

City: State:

Pincode: Email ID:

Phone No.: Mobile Number:

PAN of Claimant:

Date of Accident / Incidence: D D M M Y Y Y Y Time of Loss A.M. / P.M.

Cause of Accident / Incidence:

Details of Accident/ Incidence:

Accident/ Incidence Location Address :

City: State:

Pincode: Email ID:

Phone No.: Mobile Number:

Were there any witness to the Accident/ Incidence ☐ (Yes) ☐ (No), If 'Yes',

Name of Witness:

Address of Witness :

City: State:

Pincode: Email ID:

Phone No.: Mobile Number:

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: D D M M Y Y Y Y

Name of Person:

City: State:

Pincode: Email ID:

Phone No.: Mobile Number:

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

Name of Hospital:

City: State:

Pincode: Email ID:

Phone No.: Mobile Number:

Date of Admission : D D M M Y Y Y Y Date of Discharge: D D M M Y Y Y Y

## 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:

Policy No.:

Period of Insurance: From: D D M M Y Y Y Y to D D M M Y Y Y Y

Sum Insured Rs.: If yes please specify :

## D. 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) ☐ | | Education Grant ☐ | |
| Permanent Partial Disability(PPD) ☐ | | Hospitalisation Expenses due to Accident ☐ | |

## E. Any Other Information You May Wish To Provide:

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.

Signature

Place:_____

Date: D D M M Y Y Y Y

Name of Insured/Claimant: _____

## F. Consent & Authorization:

I _____ do hereby declare that the information given on this claim request form is true and complete to the best of my knowledge and belief and all documents submitted are genuine and duly authenticated. I/we understand that in case any of the above information is found to be false or fabricated, the Company at its discretion may repudiate the claim amount and take necessary action against me.

I hereby authorize the Hospital(s) / Doctor(s) / Laboratories who have examined or treated the deceased for any ailment or illness to provide SBI General Insurance Company Limited and its authorised representatives/claims investigators such information regarding the Insured / Policyholder's state of health which such hospital, doctor or laboratory may have acquired before or after the policy was issued on the life of_____ by SBI General Insurance Company Limited . I also authorize the Employer (including any previous employers) to provide information regarding the employment, leave record and medical assistance availed of by the Insured / Policyholder during the tenure of his employment. I further authorize any government organization/undertaking (including the Police or Revenue) to make available to the company or to person or agency as may be authorized by the said company, such information and records as may be needed by it to process a claim. I shall not have any objection, in case Company obtains any document pertaining to life Insured/Policyholder/s or me in relation to or in respect of the abovesaid Policy or otherwise as may be required.

I agree to provide and furnish any other details and reports as and when required by SBI General Insurance Company Limited for processing my claim.

| | |
|---|---|
| Full Name & Signature of Witness Signature | Full Name & Thumb Impression of Claimant |

**Vernacular Declaration:** (If the Claimant signs in vernacular or affixes a thumb impression, the witness should also sign the following)

Applicable where the Proposer is illiterate or is suffering from a disability due to which writing is restricted or where the Proposer has signed in vernacular language. (Note: The below must be witnessed by someone other than the Advisor/Employee of the Company).

I /we certify that the contents of this form were explained to the Claimant in_____ _____(language) and he/she has affixed his/her thumb impression after fully understanding the same. I, (Full name of the witness)_____(Relation with the Proposer/ Primary insured)_____adult and inhabitant of (city) and residing at_____do hereby certify that I have read out and explained the contents of the claim Form and all other documents incidental to availing the claim of said policy from SBI General Insurance Company Ltd., to the Proposer/Primary Insured and he/she/they have understood the same. I/we declare that whatever I/we have stated herein above is true and correct to the best of knowledge and belief.

| | |
|---|---|
| Name & Signature of the Witness | Name & Signature/Thumb impression of the Claimant. |

Date: D D M M Y Y Y Y

Place: _____

Contact Number/s of the Claimant:_____

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

Name of Nominee:

Relationship with Insured: Date of Birth: D D M M Y Y Y Y

Address:

City: State:

Pincode: Email ID:

Contact Details: Phone No.: Mobile Number:

* If nominee is minor, kindly provide the Legal Guardian details

Name of Guardian:

Relationship with Insured: Date of Birth: D D M M Y Y Y Y

Address:

City: State:

Pincode: Email ID:

Contact Details: Phone No.: Mobile Number:

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: D D M M Y Y Y Y

Name of nominee : _____

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

Name and address of Injured: _____

Gender: Male ☐ Female ☐ Others ☐ Date of birth / Age: D D M M Y Y Y Y

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 _____

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:

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

b) Permanent partial Disablement: ☐ (Yes) ☐ (No) If 'Yes ',

Please specify the percentage_____

a) Temporary Total Disablement: ☐ (Yes) ☐ (No ) If 'Yes',

Please specify the Duration of Temporary Total Disability_____

Details of Treatment given: _____

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 Date: D D M M Y Y Y Y To Date : D D M M Y Y Y Y

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

If 'Yes', From Date: 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 Date: _____/_____/_____

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:

Address:

City: State:

Pincode: Email ID:

Contact Details: Phone No.: Mobile Number:

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

ENCLOSURES CHECKLIST:

1.Accidental Death:

- ☐ Claim form duly signed
- ☐ Policy copy
- ☐ Certified copies of FIR / MLC Copy /Spot Panchnama / Inquest Panchnama
- ☐ Certified copies of Death Certificate
- ☐ Certified copies of Post Mortem Report (If conducted)
- ☐ Affidavit from the legal heirs of the deceased (in case nomination has not been filed by deceased)

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

- ☐ Claim form duly signed
- ☐ Policy copy
- ☐ Certified copies FIR / MLC Copy /Spot Panchnama
- ☐ Certified copies of diagnostic /Investigation reports confirming claimed disability
- ☐ Medical certificate from treating doctor confirming details of disability
- ☐ Certified copy Disability Certificate issued by competent medical practitioner
- ☐ Photograph of the injured with reflecting disablement

5. Education Grant

- ☐ Child/Spouse education ID card

6. Hospitalisation Expenses due to Accident

- ☐ Original Discharge Summary from The Hospital
- ☐ Original Medical & Investigation reports
- ☐ Original Prescriptions, payment receipt and consultation papers of the treatment.
- ☐ Any other medical, investigation reports, as applicable

Details of Any Other related document:_____