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

SBI General Bharat Griha Raksha

SBI general INSURANCE
SURAKSHA AUR BHAROSA DONO

Claim No.:_____ (To be filled in block letters)

A. POLICY HOLDER/CLAIMANT DETAILS

a) Policy No.:

b) Name as per the Policy:

c) Address :

City: State:

PIN Code: Phone No.:

Mobile No.: Email ID:

PAN: /Form 16

Brief Description of Business /Office/Industry/Occupation _____

Limits of Indemnity under the Policy (Rs.) _____

Period of Insurance D D M M Y Y Y Y to D D M M Y Y Y Y

B. DETAILS OF LOSS/ACCIDENT

Date of Loss D D M M Y Y Y Y Time of Loss _____ A.M. / P.M.

Loss Location

Address

City: State:

PIN Code: Phone No.:

Mobile No.: Email ID:

Contact Details of person/s at Loss Location

Name

Relationship with Insured _____

Describe Cause of Loss/Damage _____

Estimated Loss (Rs.)

(a) Building _____ (b) Others1 _____

(d) Others2 _____

WITNESS DETAILS	INFORMATION TO AUTHORITY
Were there any witnesses to the loss / accident? (Yes) ☐ (No), ☐ If 'Yes',	Has the loss been reported to an Authority ☐ (Yes) ☐ (No), If 'No', reason for not reporting _____
Name of Person/s:	If "Yes", provide details
Address:	Fire ☐ Police ☐ Municipality ☐ Other ☐
City:	Name of Authority
State:	Information Report No./Authority Reference No. and Date
PIN Code:	D D M M Y Y Y Y
Phone No.:	Contact Person/s:
Mobile No.:	Address:
Email ID:	

City:
State:
PIN Code:
Phone No.:
Mobile No.:
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

a) Name of Insurer:

b) Name as per the Policy:

c) Address :

City: State:

PIN Code: Phone No.:

Mobile No.: Email ID:

Policy No.:

Period of Insurance D D M M Y Y Y Y to D D M M Y Y Y Y

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:

PIN Code: Phone No.:

Mobile No.: Email ID:

E. DETAILS OF PREVIOUS LOSSES

Losses during the 3 preceding years

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

F. DETAILS OF OTHER INFORMATION

Do you wish to provide any other information? ☐ (Yes) ☐ (No), If 'Yes', specify (You may add additional Sheet/Paper, if Required)

_____

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.

Date: D D M M Y Y Y Y

Place:

Signature & Name of Insured / Claimant