SBI General Insurance Company Limited
IRDAI Reg. No. 144 dated 15/12/2009 | CIN: U66000MH2009PLC190546 | UIN: SBIPAGP24073V022324

SBI general INSURANCE
SURAKSHA AUR BHAROSA DONO

Group Loan Insurance Policy
Claim Form

Master Policy Number | Certificate of Insurance Number
Claim Number | Period of Insurance

Type of benefit claimed: - Accidental death/Permanent Total Disability/Critical Illness/Admission benefit/ Loss of job/Incident benefit

DETAILS OF INSURED/CLAIMANT

Name of the Claimant
Name of the insured
Relationship with the insured | Date of Birth (D D M M Y Y Y Y) | Gender ☐ M ☐ F
Address
Street
City | District
State | Pin Code
Contact Details — Phone No. | Mobile
E-mail Id
Loan Account Number | Loan Type
Loan Amount Disbursed | Loan Amount Outstanding

(Please submit duly filled Bank certificate as in annex)

DETAILS OF ILLNESS/ACCIDENT/INCIDENCE

SECTION I PERSONAL ACCIDENT

Date of Accident / Incidence (D D M M Y Y Y Y) | Time of Accident / Incidence ____ A.M. ____ P.M.
Details of Accident/ Incidence _____

Accident/ Incidence Location Address
Street
City | District
State | Pin Code
Phone Number of Claimant — Phone No. | Mobile
E-mail Id
Were there any witness to the Accident/ Incidence ☐ Yes ☐ No
Name of Person
Address
Street
City | District
State | Pin Code
Phone Number of Claimant — Phone No. | Mobile
E-mail Id
A. Accidental Death (D D M M Y Y Y Y) | B. Date of Death (D D M M Y Y Y Y) | C. Place of Death
D. Name of hospital where insured was admitted immediately post accident (if applicable):
Permanent Total Disability | Nature of Disability
Name & Address of Certifying authority:
Street
City | District
State | Pin Code

Name & Address of Hospital where Insured was treated

Street

City District

State Pin Code

Signs and Symptoms of illness

SECTION II: CRITICAL ILLNESS:

Diagnosis of Illness:

1. Cancer of specific severity
2. Myocardial Infarction (First Heart Attack of Specific Severity)
3. Open Chest CABG
4. Open Heart Replacement or Repair of Heart Valves
5. Coma of Specified Severity
6. Kidney Failure Requiring Regular Dialysis
7. Stroke Resulting in Permanent Symptoms
8. Major Organ/ Bone Marrow Transplant
9. Permanent Paralysis of Limbs
10. Multiple Sclerosis with Persisting Symptoms
11. Blindness
12. Primary (Idiopathic) Pulmonary Hypertension
13. Aorta Graft Surgery
14. Benign Brain Tumor
15. Motor Neurone Disease with Permanent Symptoms

Name of the investigation with the results confirming diagnosis: _____

Date of disease first detected: D D M M Y Y Y Y

Have you ever had the similar condition in past ☐ Yes ☐ No. If 'Yes', provide details, _____

Date of first visit to Hospital in this regard: D D M M Y Y Y Y

OP Number/Hospital No/Indoor Patient No.: _____

Date of last visit: D D M M Y Y Y Y Frequency of visits (Weekly/Monthly/Other): _____

Name of the Hospital

Phone No. Mobile

E-mail Id

Name of Treating Doctor:

Qualification of treating Doctor: Treating Doctors Registration No.:

Address

Street

City District

State Pin Code

Phone Number Phone No. Mobile

E-mail Id

Progress: ☐ Death ☐ Recovered ☐ Improved ☐ Unimproved ☐ Retrogressed

In case of death, date of death: D D M M Y Y Y Y

SECTION III: ADMISSION BENEFIT - ACCIDENTAL HOSPITALIZATION

Date of Accident: D D M M Y Y Y Y

Date of Admission: D D M M Y Y Y Y Time of Admission A.M. P.M.

Date of Discharge: D D M M Y Y Y Y Time of Discharge A.M. P.M.

Type of Injury/Diagnosis: Any other past history:

Name of the Hospital

Name of the Treating Doctor:

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:

Address

Street

City District

State Pin Code

Phone Number Phone No. Mobile

E-mail Id

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

Name of Hospital

Address

Street

City District

State Pin Code

Phone Number of Claimant Phone No. Mobile

E-mail Id

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

In case of death, Has the cause of death certified by competent authority _____

Has Post mortem examination conducted: _____

Viscera/blood sample preserved for analysis? _____

Status of Viscera/chemical analysis report: ☐ Received ☐ Pending ☐ Not sent for examination

DETAILS OF PREVIOUS CLAIM

Have you incurred any claim before? ☐ Yes ☐ No, If 'Yes'

Name of Insurer

Policy Issuance office Location:

Policy No. Period of Insurance to

Sum Insured Rs.

Any other Information :

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: D D M M Y Y Y Y

Name of Insured/Claimant _____

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

Name of Nominee

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

Insured Address

Street

City District

State Pin Code

Phone Number Phone No. Mobile

E-mail Id

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

Name of Guardian

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

Insured Address

Street

City District

State Pin Code

Phone Number 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:

Signature

Date: D D M M Y Y Y Y

Name of Nominee _____

ANNEX 2: DETAILS OF FAMILY MEMBER REQUIRED FOR DEPENDANT BENEFIT IN CASE OF CRITICAL ILLNESS CLAIM (INCLUDING NEFT DETAILS)

Name of Dependent Claimant:

Relationship with insured:

Dependant's Bank Account details: Bank Name: Branch:

Savings Account No: IFSC Code:

MICR Code: (Please attach copy of first page of bank passbook/cancelled cheque/letter from bank confirming account details with name of account holder, IFSC & MICR details)

ANNEX 3: BANK CERTIFICATE FORM

CERTIFICATE OF BANK

This is to certify that Mr. / Mrs. _____ is a holder of Loan account No._____.

The Loan Account was held by the aforesaid person. The original Loan amount Rs. _____ was disbursed on _____.

The total outstanding principle loan amount including interest thereof is Rs._____ as on date of loss i.e. _____ of the above account holder. The Details of his/her loan account are as below.

Loan Account Number: _____ Loan Type: _____ Loan Tenure: _____

Last EMI due date: _____ Monthly EMI _____

Current loan status if closed date of closure: _____ Loan outstanding amount: _____

Principle outstanding as on date of loss: _____ Interest amount outstanding as on date of loss: _____

Overdue charges /penalties (if any): _____

AUTHORISED SIGNATORY STATE BANK OF INDIA

NAME OF THE SIGNATORY : _____ SIGN AND STAMP : _____

BRANCH : _____ BRANCH CODE : _____

PLACE : _____ DATE : _____

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

DETAILS OF ACCOUNT TO WHICH CLAIM AMOUNT SHOUD BE REMITED

(To be filled & certified by bank only)

Copy of bank passbook/cheque to be attached if claim to be paid in favour of insured or legal heirs

Name of the Loan Account/Beneficiary Bank Account:

Bank Name:

Branch and Address:

Street

City

District

State

Pin Code

Loan A/C No:

IFSC Code:

MICR Code:

Pan No:

E-mail ID (Branch e-mail):

I, hereby authorize SBI General Insurance Co. Ltd. to make the payment of claim in respect of Account Nos. _____ to above referred Bank Account and I confirm the Bank account details furnished as above are correct.

Name of Branch Manager: _____

Signature: _____

Date: _____

Place: _____