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

BAGGAGE 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 additional 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 / /Occupation/Profession

_____

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_____

Please provide the details of the person who discovered the loss.

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

_____

_____

_____

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_____