SBI general INSURANCE
SURAKSHA AUR BHAROSA DONO

(A joint venture between of State Bank of India and Insurance Australia Group)

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

CLAIM FORM

Please tick the appropriate check box

☐ Public Liability Act ☐ Public Liability ☐ Commercial General Liability ☐ Product Liability

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

Policy Number_____ Period of Insurance _____ to _____

Claim Number_____ Retroactive date, if any: _____

A. DETAILS OF INSURED/CLAIMANT:

Name of the Insured : _____

Address _____

City_____State_____Pin Code_____

Phone Number : _____ Mobile Number _____ Email ID_____

Trade or Business _____ Date of Last Premium Paid _____

Limits of Indemnity under the policy _____

B. DETAILS OF LOSS:

Date of Loss _____/_____/_____ Time of Loss _____A.M. / P.M.

How did accident / incident occur? Give full details and description on back of form illustrated by rough sketch if necessary :_____

Place Accident Occurred with full address details :_____

_____

Is the cause of accident attributable to negligence of any of your employee/s ☐ (Yes) ☐(No), If 'Yes',

Occupation _____ Name_____ Address _____

Is the cause of accident attributable to any person NOT in your employ ☐ (Yes) ☐(No), If 'Yes',

Occupation _____ Name_____ Address _____

Is the cause of accident attributable to work being carried out under contract, ☐ (Yes) ☐(No), If 'Yes',

Has any indemnity or disclaim been given or received, pl. provide details _____

_____

Detail act of negligence :_____

Is the cause of accident attributable to any defect in your ways, works, machinery, plant or premises?

☐ (Yes) ☐(No), If 'Yes', Please state exact nature of defect

_____

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WITNESS DETAILS	INFORMATION TO STATUTORY AUTHORITY
Were there any witnesses to the loss / accident?	Has the loss been reported to an Authority
☐(Yes) ☐(No), If 'Yes',	☐ (Yes) ☐(No),
Name of Person/s_____	Name of Authority _____
Address _____	Authority Reference No. _____
_____	Contact Person/s_____
City_____	Address _____
State_____	_____
Pin Code_____	City _____State_____
Phone Number _____	Pin Code_____
Mobile Number_____	Phone Number _____
Email ID _____	Mobile Number_____
	Email ID _____

C. DETAILS OF OTHER INSURANCE/INTEREST

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 _____

Policy No._____ Period of Insurance _____to_____

Sum Insured (Rs.)_____

D. THE INJURED / DECEASED PERSON *

Name and address of Injured/deceased : _____

Gender: ☐ (Male) ☐(Female), Age: _____

Address _____

City_____State_____PinCode_____

Phone Number _____ Mobile Number_____

State occupation / nature of work of the injured person _____

Was the Injured/deceased person engaged in this occupation when the accident occurred? _____

If "No", state exactly the nature of the work he/she was doing at the time of accident

_____

Is the Injured/deceased person in your direct employment? ☐ (Yes) ☐(No),

Any Relationship between you and the injured ? _____

Have the Injured/deceased persons been taken to hospital or medically attended? ☐ (Yes) ☐(No),

If "Yes", specify Name of Hospital / Physician _____

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Date of Admission ____/____/_____ Date of Discharge ____/____/_____

State nature of injury & part of body affected _____

Is there disablement? ☐ (Yes) ☐(No),

If "Yes" select ☐Total ☐ Partial ☐ Permanent ☐ Temporary

Is the disability solely caused by this accident / Incident ☐ (Yes) ☐(No),

If "No", give details _____

How long is the disablement expected to last? _____ Days Upto ____/_____/_____

Extent of disability _____%

Was the injured person under the influence of alcohol or drugs at the time of accident? ☐ (Yes) ☐(No),

Present health condition _____

In event of Death: Post Mortem Done ☐ (Yes) ☐(No), Date of PM Done ____/____/_____ PM No. _____ Name and address of Hospital where Post mortem has been done

_____

* In the event of more than one person being injured/dead, please provide the indiividual detials as detailed above in a separate annexure

E. DAMAGE DETAILS

Name and address of the owner of damaged property _____

_____

Nature and extent of damaged property _____

Estimated Cost of Repair _____

F. PRODUCT DETAILS (To be filled, in case of claim under Product Liability)

Describe the Product involved including its standards and specifications :

Was the product ☐ Sold, ☐ Supplied, ☐ Manufactured by you?

When was the product put into circulation (Date) _____

Identification of the defective lot of product involved :_____

Is the defective product caused by some defective raw material or parts provided by independent supplier(s) or contractor(s)? ☐ (Yes) ☐(No), If 'Yes', please specify details and identity (ies) of those party (ies)? _____

_____

_____

Please specify the defective parts of the product concerned and confirm whether any testing has been carried out to indentify the problem, ? ☐ (Yes) ☐(No), If 'Yes', please provide us with a copy of the internal/external testing report, if available.

When and from whom was the product purchased by the injured / damaged party?

_____

Have you Inspected the Product? ☐ (Yes) ☐(No)

Have you notified all other parties who may have an interest in the product? ☐ (Yes) ☐(No)

Has any communication, verbal or written been made to you or on behalf of any injured person or owner of

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damaged property, ☐ (Yes) ☐(No) if yes, please give particulars :

_____

Give the details of Statute/ Law under which in your opinion liability may arise :

Give Full Details of the Accident including a sketch, if possible :

Sketch:

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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: Insured's Signature with Company Seal:

Date: _____