SBI General Insurance Company Limited

SURAKSHA AUR BHAROSA DONO

Call (Toll Free)
1800 22 1111/ 1800 102 1111
www.sbigeneral.in

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

CLAIM FORM -DIRECTORS & OFFICERS LIABILITY INSURANCE (D & O)

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

Important Notice

- Please read this claim form fully before answering the questions.
- All questions must be answered as fully as possible. Please use additional sheets if necessary and copies of relevant documentation should be attached.
- Please send the completed claim form, as soon as possible to us
- Appointment of legal representatives should not occur without our prior consent.

Policy Number_____ Period of Insurance _____ to _____

Claim Number_____

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:

1. Details of Insured Company or Directors/ Officers Giving Notification of a Claim or circumstances That May Give Rise to a Claim

Full name of the Insured Company giving notification :
Full name & position of the directors/officers giving notification :
Address of the Insured Company or directors/officers giving notification :

2. Details Of The Relevant Insured Person(s)

Full name and position of the Insured Person(s) who is/are the subject of the claim or circumstance.
Name of the Insured entity of which such Insured Person(s) is/are a director/officer or employee, if not the Insured Company.

3. Details Of Claimant

Full name of the claimant or potential claimant (i.e. the party making the claim or potential claim upon the Insured).
Address of the claimant.

4. Details Of The Subject Activity

From what activity on the part of the Insured does the claim or circumstance arise?
Was the performance or undertaking of such activity evidenced in writing? If so, please attach a copy. If not, please provide relevant information.
When was the activity from which the claim arises or may arise performed or undertaken?

5. Details of Claim or Circumstance

What is the precise nature of the claim (i.e. the claimant's allegations) or the fact or circumstance that might give rise to a claim?
Have proceedings been commenced? If so, please attach a copy of the court documents.
On what date did you first become aware of the claim or of the fact or circumstance?
On what date was the claim or the intimation of a claim first made to you?
Was the first intimation of a claim oral or in writing? If in writing please attach a copy. If oral, please give a "first person" account of the conversation, (i.e. "I said", "He said").
What amount, if any, is claimed? If known, what does that amount comprise?

6. Details of Insured's Response

What are your comments in response to the claim or the fact or circumstance that might give rise to a claim?
What are your comments on the quantum of the claim and what is your estimate of your Potential monetary liability, if any, to the claimant?
Have you appointed a solicitor or other lawyer to act for you? If so, what is the lawyers name, Firm, address and charge out rates?

WITNESS DETAILS	INFORMATION TO STATUTORY AUTHORITY
Were there any witnesses to the Incident? ☐(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), Name of Authority _____ Authority Reference No. _____ Contact Person/s_____ Address _____ _____ City _____State_____ Pin Code_____ Phone Number _____ Mobile Number_____ Email ID _____

C. DETAILS OF OTHER INSURANCE/INTEREST

Is the Incident 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. DETAILS OF PREVIOUS LOSSES

Losses during the 3 preceding years

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

E. DETAILS OF OTHER INFORMATION

Do you wish to provide any other information? ☐(Yes) ☐(No), If 'Yes', specify

_____

_____

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

_____

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: _____