



SURAKSHA AUR BHAROSA DONO

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

MACHINERY/ELECTRONIC EQUIPMENT INSURANCE 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 other 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 /Office/Industry/Occupation _____ _____			
Limits of Indemnity under the Policy (Rs.) _____			

B. DETAILS OF LOSS/DAMAGE

Date of Loss ____/____/____		Time of Loss _____ A.M. / P.M.	
Loss Location			
Address _____ _____			
City _____		State _____	Pin Code _____
Contact Details of person/s at Loss Location			
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 / damage? <input type="checkbox"/> (Yes) <input type="checkbox"/> (No), If 'Yes', Name of Person/s _____ Address _____		Has the loss been reported to an Authority <input type="checkbox"/> (Yes) <input type="checkbox"/> (No), If 'No', reason for not reporting _____ If "Yes", provide details <input type="checkbox"/> Fire <input type="checkbox"/> Police <input type="checkbox"/> Municipality <input type="checkbox"/> Other Name of Authority _____ Information Report No./Authority Reference No. and Date _____	



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City _____ State _____ Pin Code _____ Phone Number _____ Mobile Number _____ Email ID _____	_____ Contact Person/s _____ Address _____ _____ City _____ State _____ Pin Code _____ Phone Number _____ Mobile Number _____ Email ID _____
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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 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 _____ PinCode _____

Phone Number _____ MobileNumber _____ EmailID _____

E. DETAILS OF ITEMS AFFECTED

Sl. No.	Description of Equipment	Manufacturer	Year of Manufacture	Identification/ Machine/Serial No.	Sum Insured (Rs.)	Date of Last Maintenance	Date of Expiry of AMC/Warranty	Cost of Repair/Replacement (Rs.)

Has the affected equipment undergone any repairs previously? (Yes) (No)
 If "Yes", the nature of such repairs _____



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Date of Repair	Nature of Repair	Parts affected	Cost of Repair (Rs.)

F. DETAILS OF REPAIR/REPAIRER

Is the repair being carried out in house? (Yes) (No),
 If 'Yes', specify and submit Job-Work estimates along with Pro-forma Invoices of Spare Parts to be replaced
 If " No" specify following details
 Name of the Repairer _____
 Name of contact person/s _____
 Address _____
 City _____ State _____ PinCode _____
 Phone Number _____ MobileNumber _____ EmailID _____

G. DETAILS OF PREVIOUS LOSSES

Losses during the 3 preceding years

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

H. 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 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 thereunder shall be forfeited.

Place _____

Signature _____

Date _____

Name of Insured/Claimant _____