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INDUSTRIAL ALL RISK 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 such particulars may be sent later.

Policy No. Claim No.

Period of Insurance From D D M M Y Y Y Y To D D M M Y Y Y Y

A. DETAILS OF INSURED/CLAIMANT

1. Name as per Policy — SURNAME MIDDLENAME FIRSTNAME
2. Address — Plot No/Door No. Building Name; Road Area; City Pincode; State
3. Contact Details — Phone No. Mobile; E-mail Id
4. Brief Description of Business /Office/Industry/Occupation
5. Limits of Indemnity under the Policy (Rs.)

B. DETAILS OF LOSS/ACCIDENT

1. Date of Loss — D D M M Y Y Y Y Time of Loss : a.m./p.m.
2. Loss Location Address — Plot No/Door No. Building Name; Road Area; City Pincode; State
3. Contact Details of person/s at Loss Location
   - Name — SURNAME MIDDLENAME FIRSTNAME
   - Relationship with Insured
   - Contact Details — Phone No. Mobile; E-mail Id
4. Describe Cause of Loss/Damage
5. Estimated Loss (Rs.)

WITNESS DETAILS

1. Were there any witnesses to the loss/accident? ☐ Yes ☐ No

If 'Yes',

2. Name as Person/s — SURNAME | MIDDLENAME | FIRSTNAME

3. Address — Plot No/Door No. | Building Name | Road | Area | City | Pincode | State

4. Contact Details — Phone No. | Mobile | E-mail Id

INFORMATION TO AUTHORITY

1. Has the loss been reported to an Authority? ☐ Yes ☐ No

If 'No', reason for not reporting _____

If 'Yes', provide details ☐ Fire ☐ Police ☐ Municipality ☐ Other

2. Name of Authority

3. Information Report No./ Authority Reference No. — Date (DDMMYYYY)

4. Contact Person/s — SURNAME | MIDDLENAME | FIRSTNAME

5. Address — Plot No/Door No. | Building Name | Road | Area | City | Pincode | State

6. Contact Details — Phone No. | Mobile | E-mail Id

C. DETAILS OF OTHER INSURANCE

1. Is the loss/damage covered under any other Insurance? ☐ Yes ☐ No

If 'Yes', specify details and attach a copy of the policy _____

2. Name of Insurer

3. Address — Plot No/Door No. | Building Name | Road | Area | City | Pincode | State

4. Contact Details — Phone No. | Mobile | E-mail Id

5. Policy No.

6. Period of Insurance — From (DDMMYYYY) To (DDMMYYYY)

7. Sum Insured (Rs.)

D. DETAILS OF OTHER INTEREST

1. Is the Insured the Sole Owner of the property? ☐ Yes ☐ No

   If 'No', specify

2. Nature of Interest _____

3. Person/s who has/have interest on property

4. Address
   Plot No/Door No. | Building Name
   Road | Area
   City | Pincode
   State

5. Contact Details
   Phone No. | Mobile
   E-mail Id

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

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

F. DETAILS OF REPAIR/REPAIRER

1. 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

2. Name of the Repairer

3. Name of contact person/s

4. Address
   Plot No/Door No. | Building Name
   Road | Area
   City | Pincode
   State

5. Contact Details
   Phone No. | Mobile
   E-mail Id

G. DETAILS OF CONSEQUENTIAL LOSS

1. Whether any alteration has been made in the nature of business/occupation of premises after inception of Policy? ☐ Yes ☐ No

   If 'Yes', please give details _____

2. Were the premises occupied at the time of loss? ☐ Yes ☐ No

   If 'No', un-occupied since (date) D D M M Y Y Y Y for (specify reason/s) _____

Details of Damage under Material Damage Section under IAR Policy:

3. Name of Insurer

4. Address — Plot No/Door No. | Building Name | Road | Area | City | Pincode | State

5. Contact Details — Phone No. | Mobile | E-mail Id

6. Policy No.

7. Period of Insurance — From D D M M Y Y Y Y To D D M M Y Y Y Y

8. Sum Insured (Rs.)

   a) Building | b) P&M | c) FFF | d) Stocks | e) Others 1 | f) Others 2

9. Occupation of premises at the time of loss: ☐ Manufacturing Facility ☐ Warehouse ☐ Shop ☐ Office ☐ Dwelling

10. Estimated Loss Material Damage (Rs.)

    a) Building | b) P&M | c) FFF | d) Stocks | e) Others 1 | f) Others 2

11. Period for which the business was interrupted due to Fire and Special Perils/MBD D D M M Y Y Y Y To D D M M Y Y Y Y

12. What was the annual turn-over for the last financial year? Rs. _____

13. What is the estimated reduction in turn-over due to interruption? Rs. _____

14. What is the estimated loss of Gross Profit due to interruption? Rs. _____

15. Standing Charges/Expenses incurred for Loss Minimization, if any Rs. _____

16. Were there any person/organization, in your opinion, responsible for the loss? ☐ Yes ☐ No

    If 'Yes', please provide details along with contact numbers and address, if available (this information will be used only for investigation of this claim and source will not be divulged to the suspected party)

    _____

    _____

    _____

17. What steps have been taken to prevent recurrence of similar incidence?

    _____

    _____

    _____

H. DETAILS OF PREVIOUS LOSSES

Losses during the 3 preceding years

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

G. 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 there under in respect of past or future loss/accident shall be forfeited.

Place _____ Signature of Insured/Claimant _____

Date: D D M M Y Y Y Y Name of Insured/Claimant _____