SBI general INSURANCE
SURAKSHA AUR BHAROSA DONO

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

LOAN INSURANCE POLICY

Claim Form

Issuance of this form does not amount to admission of any liability or a waiver of any of the terms and conditions of the insurance contract. If any claim is in any manner dishonest or fraudulent, or is supported by any dishonest or fraudulent means or devices, whether by You or any Insured Person or anyone acting on behalf of You or an Insured Person, then this Policy shall be void and all benefits paid under it shall be forfeited.

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 of the Insured — SURNAME MIDDLE NAME FIRST NAME
2. Name of the Claimant — SURNAME MIDDLE NAME FIRST NAME
3. Name of Hospitalized Person — SURNAME MIDDLE NAME FIRST NAME
4. Relationship with Insured ______________
5. Date of Birth D D M M Y Y Y Y — Gender ☐ Male ☐ Female
6. Address — Plot No/Door No. ______ Building Name ______
   Road ______ Area ______
   City ______ Pincode ______
   State ______
7. Contact Details — Phone No. ______ Mobile ______
   E-mail Id ______

B. DETAILS OF ILLNESS/ACCIDENT/INCIDENCE

SECTION I – CRITICAL ILLNESS

1. Signs and symptoms of illness______________________________
2. Diagnosis of illness
   - ☐ Cancer ☐ Coma ☐ Aorta Surgery ☐ Coronary Artery Bypass Grafting
   - ☐ Heart Valve Replacement ☐ Stroke ☐ Major Organ Transplant
   - ☐ Myocardial Infarction (First Heart Attack) ☐ Aorta Graft Surgery ☐ Multiple Sclerosis
   - ☐ Kidney Failure (End Stage Renal Failure) ☐ Third Degree Burns ☐ Total Blindness
3. Name of the investigation with the results confirming diagnosis ______________
4. Date of disease first detected D D M M Y Y Y Y
5. Have you ever had the similar conditions in past? ☐ Yes ☐ No
   If 'Yes', provide details, ______________________________
6. Date of first visit to Hospital in this regard D D M M Y Y Y Y — Date of last visit D D M M Y Y Y Y

Version 1.1, Nov 2011

7. Frequency of visits ☐ Weekly ☐ Monthly ☐ Other ____________

8. Name of the Hospital

9. Contact Details — Phone No. / Mobile

E-mail Id

10. Address of Hospital — Plot No/Door No. / Building Name

Road / Area

City / Pincode

State

11. Name of Treating Doctor

12. Qualification of Treating Doctor / Treating Doctors Registration No.

13. Contact Details — Phone No. / Mobile

E-mail Id

14. OP No. / Hospital No. / Indoor Patient No.

15. Progress ☐ Recovered ☐ Improved ☐ Unimproved ☐ Retrogressed

SECTION II – PERSONAL ACCIDENT

1. Date of Accident/Incidence D D M M Y Y Y Y — Time of Accident/Incidence : A.M. / P.M.

2. Cause of Accident/Incidence

3. Details of Accident/Incidence ____________

4. Accident/Incidence Location Address — Plot No/Door No. / Building Name

Road / Area

City / Pincode

State

5. Contact Details — Phone No. / Mobile

E-mail Id

6. Were there any witness to the Accident/Incidence? ☐ Yes ☐ No

7. Name of Person

8. Address — Plot No/Door No. / Building Name

Road / Area

City / Pincode

State

9. Contact Details — Phone No. / Mobile

E-mail Id

SECTION III – LOSS OF JOB/EMPLOYMENT

1. Name of Bank / Financial Institution
2. Address — Plot No/Door No. | Building Name | Road | Area | City | Pincode | State
3. Contact Details — Phone No. | Mobile | E-mail Id
4. Loan Account No. | Loan Type
5. Amount of Loan Rs. | EMI Rs.
6. Date of Loan Disbursement D D M M Y Y Y Y | Tenure of Loan Months
7. Date of last EMI paid D D M M Y Y Y Y | Amount of last EMI paid
8. Name of Employer
9. Address — Plot No/Door No. | Building Name | Road | Area | City | Pincode | State
10. Contact Details — Phone No. | Mobile | E-mail Id
11. Date of Appointment/Joining D D M M Y Y Y Y | Designation
12. Date of Termination / Suspension/ Retrenchment D D M M Y Y Y Y
13. Reasons for Termination
14. Date of Reinstatement (in case of Suspension) D D M M Y Y Y Y

C. INFORMATION TO AUTHORITY

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

   If 'No', reason for not reporting

   If 'Yes', provide details ☐ Police ☐ Other
2. Name of Authority
3. First Information Report/ MLC No. | Report Date D D M M Y Y Y Y
4. Name of Person
5. Address — Plot No/Door No. | Building Name | Road | Area | City | Pincode | State
6. Contact Details — Phone No. | Mobile | E-mail Id

7. Was the person moved to hospital immediately after the accident? ☐ Yes ☐ No

If 'Yes',

Name of Hospital

Address of Hospital — Plot No/Door No. — Building Name

Road — Area

City — Pincode

State

Contact Details — Phone No. — Mobile

E-mail Id

8. Date of Admission D D M M Y Y Y Y — Date of Discharge D D M M Y Y Y Y

D. DETAILS OF PREVIOUS CLAIM

1. Have you incurred any claim before? ☐ Yes ☐ No

If Yes, please provide details

Name of Insurer

Policy issuance office location

Policy No. — Sum Insured Rs.

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

E. DETAILS OF OTHER INSURANCE/INTEREST

1. Is the Accident/Incidence covered under any other Insurance? ☐ Yes ☐ No

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

Name of Insurer

Policy issuance office location

Policy No. — Sum Insured Rs.

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

F. 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

ANNEXURE I: TO BE COMPLETED BY NOMINEE IN THE EVENT OF INSURED'S DEATH

1. Name of the Nominee — SURNAME MIDDLENAME FIRSTNAME
2. Relationship with Insured — Date of Birth DDMMYYYY
3. Address — Plot No/Door No. — Building Name
   Road — Area
   City — Pincode
   State
4. Contact Details — Phone No. — Mobile
   E-mail Id

*If nominee is minor, kindly provide the Legal Guardian details

1. Name of the Guardian — SURNAME MIDDLENAME FIRSTNAME
2. Relationship with Insured — Date of Birth DDMMYYYY
3. Address — Plot No/Door No. — Building Name
   Road — Area
   City — Pincode
   State
4. Contact Details — Phone No. — Mobile
   E-mail Id

I hereby declare that the information furnished in this claim form is true and correct to the best of my knowledge and belief. If I have made any false or untrue statement, suppression or concealment of any material fact with respect to questions asked in relation to this claim, my right to claim reimbursement shall be forfeited. I also consent and authorize TPA/insurance company, to seek necessary medical information/documents from any hospital/Medical Practitioner who has attended on the person against whom this claim is made. I hereby declare that I have included all the bills/receipts for the purpose of this claim and that I will not be making any supplementary claim except the pre/post-hospitalization claims, if any (for indemnity policies only). I/We also hereby declare that I am/we are accepting the amount in full discharge of your obligations under the policy to the Insured Person and /or his/her legal heirs. I/we will hold you indemnified in the event of any claim under this policy being made against you by any other person or persons.

Place

Date: DDMMYYYY

Signature ______________________

Name of Nominee/Guardian ______________________
(in case of minor)