SURAKSHA AUR BHAROSA DONO

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

Corporate 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

| 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__________ | City__________State__________ |
| Pin Code__________ | Pin Code__________ |
| Phone Number __________ | Phone Number __________ |
| Mobile Number__________ | Mobile Number__________ |
| Email ID __________ | 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 ____________________________________________

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 ☐ TemporaryIs

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

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: ______________________________