SBI General Insurance Company Limited
IRDA Reg. No. 144 dated 15/12/2009 | CIN: U66000MH2009PLC190546

SBI general INSURANCE
SURAKSHA AUR BHAROSA DONO

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

GROUP PERSONAL ACCIDENT INSURANCE POLICY

Claim Form (For SBI & its Associate Bank Account Holders Only)

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 the Insured Person/Claimant or anyone acting on behalf of the Insured Person, then the benefits under this policy shall be void and all benefits payable 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 Claimant SURNAME MIDDLENAME FIRSTNAME
2. Name of the Insured SURNAME MIDDLENAME FIRSTNAME
3. Relationship with Insured ____ Designation (if applicable) ____
4. Date of Birth of Insured D D M M Y Y Y Y Gender ☐ Male ☐ Female
5. Address Plot No/Door No. ____ Building Name ____
   Road ____ Area ____
   City ____ District ____
   State ____ Pincode ____
6. Contact Details Phone No. ____ Mobile ____
   E-mail Id ____

B. DETAILS OF ACCIDENT/INCIDENCE

1. Date of Accident/Incidence D D M M Y Y Y Y Time of Loss __ : __ A.M. / P.M.
2. Cause of Accident/Incidence ____
3. Details of Accident/Incidence ____
4. Accident/Incidence Location Address ____ Pincode ____
5. Were there any witness to the Accident/Incidence? ☐ Yes ☐ No
   If 'Yes', provide details,
   Name of Witness ____
   Address of Witness ____ Pincode ____
   Contact Details Phone No. ____ Mobile ____
   E-mail Id ____
6. Is Witness relative of Claimant? ☐ ☐ Yes No

Version 1.6, Aug 2014

Corporate & Registered Office: 'Natraj', 301, Junction of Western Express Highway & Andheri - Kurla Road, Andheri (East), Mumbai - 400 069.

C. INFORMATION TO POLICE AUTHORITY

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

If 'No', reason for not reporting

First Information Report No. Medico Legal Case (MLC) No.

Report Date D D M M Y Y Y Y

Address of Police Station

Pincode

Contact Details Phone No. Mobile

E-mail Id

2. Was the person moved to hospital immediately after the accident? ☐ Yes ☐ No
If 'Yes',
3. Name of Hospital

Address of Hospital

Pincode

Contact Details Phone No. Mobile

E-mail Id

4. 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 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 No.

Policy Issuance Office Location 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. FOR WHICH BENEFIT DO YOU CLAIM? [PLEASE TICK ( ) THE APPROPRIATE BOX]

Benefit	Amount Claimed
☐ Accidental Death	

F. PAYEE DETAILS [Payable to Nominee (*All fields are mandatory)]

Bank Name Bank Branch

Bank Account No. IFSC Code

MICR No. PAN No.

Note: It is agreed that the Policyholder/Claimant will intimate in writing to SBI General about any change in bank account details. Please attach a cancelled cheque pertaining to the same account. In case premium is issued from the same bank account through cheque, the cancelled cheque is not required.

G. ANY OTHER INFORMATION YOU MAY WISH TO PROVIDE

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 that the Company may require in respect of the said accident or any false or fraudulent statement, or any suppression or concealment, my/our claim shall be absolutely forfeited.

Place Signature of Insured/Claimant

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

H. ENCLOSURES CHECKLIST

Accidental Death:

- [ ] Claim Form duly signed and attested by respective authorised SBI or its Associate Bank's official
- [ ] Original Certificate of Insurance
- [ ] Copy of Death Certificate attested by issuing authorities
- [ ] Copy of Final Police Report attested by issuing authorities
- [ ] Copy of FIR / MLC Copy / Spot Panchnama / Inquest Panchnama attested by issuing authorities
- [ ] Affidavit from the legal heirs of the deceased (in case nomination has not been filed by deceased)
- [ ] Copy of Post Mortem Report attested by issuing authorities
- [ ] Cancelled Cheque of Nominee

Note: The Company reserves the right to seek additional documents (including KYC documents) and information as and when necessary for processing of the Claim.

I. STATE BANK OF INDIA & ITS ASSOCIATE BANKS AUTHENTICATION

This is to certify that Mr / Ms ______________________ having account number ______________________

in ______________________ Branch, Branch Code ______________________ is / was covered under Group Personal Accident Master

Policy No. ______________________, Certificate No. ______________________ for Sum Insured Rs.______________________.

Nominee details which are provided above are valid as per our records. ☐ Yes ☐ No ☐ Not Applicable

The above information is true to best of my knowledge and we agree to provide any further information that may be required.

Place: ______________________

Date: D D M M Y Y Y Y

Signature of Authorized Personnel: ______________________

Name of Authorized Personnel: ______________________

Bank Branch Seal:

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

1. Name of Nominee: SURNAME MIDDLE NAME FIRST NAME
2. Relationship with Insured: ______________________ Date of Birth: D D M M Y Y Y Y
3. Address: ______________________ Pincode: ______
4. Contact Details: Phone No. ______________________ Mobile ______________________
   E-mail Id ______________________

If nominee is minor, kindly provide the Legal Guardian details

5. Name of Guardian: SURNAME MIDDLE NAME FIRST NAME
6. Relationship with Insured: ______________________ Date of Birth: D D M M Y Y Y Y
7. Address: ______________________ Pincode: ______
8. 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 D D M M Y Y Y Y

Signature ______________________

Name of Nominee ______________________

ANNEXURE II: MEDICAL CERTIFICATE - TO BE FILLED BY TREATING DOCTOR

1. Name & Address of the Insured: SURNAME MIDDLE NAME FIRST NAME

2. Gender: ☐ Male ☐ Female Date of Birth / Age: DD MM YYYY /

3. Nature of the Accident/Incident and details of injuries sustained ______

4. Cause of Accident/Incident ______

5. Is death:

   a) Solely due to Accident/Incident ☐ Yes ☐ No

   b) Traceable to any disease ☐ Yes ☐ No

   If 'Yes', give details ______

   c) Traceable to any previous injury ☐ Yes ☐ No

   If 'Yes', give details ______

6. Was insured under influence of drugs / intoxicants / alcohol at the time of accident? ☐ Yes ☐ No

7. Was the insured suffering from any disease or injury which may have contributed to the accident or likely to aggravate his/her condition? ☐ Yes ☐ No

   If 'Yes', give details ______

I certify that I have examined the above named Insured, the above statements are correct and that the injured person is necessarily disabled by the accident referred to

Name of treating Doctor

Qualifications Registration No.

Address

Contact Details Phone No.

E-mail Id

Signature of the Doctor ______ Date DD MM YYYY

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