SBI General Insurance Company Limited
Corporate & Registered Office: Fulcrum Building, 9th Floor, A & B Wing, Sahar Road, Andheri (East), Mumbai 400 099.

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

Registered Office: Corporate Centre, State Bank Bhavan, Madame Cama Road, Mumbai - 400 021.

ALL RISK 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 such particulars may be sent later

Policy Number___________________________ Period of Insurance ____________ to ____________

Claim Number___________________________

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A. DETAILS OF INSURED/CLAIMANT

Name as per policy____

Address ____
____

Contact Details
City____________________ State______________________ Pin Code______________
Phone Number ______________ Mobile Number____________ Email ID ____________________

Brief Description of Business /Office/Industry/Occupation
____

B. DETAILS OF LOSS/ACCIDENT

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 / accident? ☐(Yes) ☐(No), If 'Yes', Name of Person/s________________________ ________________________ Address ________________________ ________________________ City__________ State__________ Pin Code________________________ Phone Number ________________________ Mobile Number________________________ Email ID ________________________	Has the loss been reported to an Authority ☐ (Yes) ☐(No), If 'No', reason for not reporting________________________ If "Yes", provide details ☐Fire ☐Police ☐Municipality ☐Other Name of Authority ________________________ Information Report No./Authority Reference No. and Date ________________________ Contact Person/s________________________ Address ________________________ ________________________ City__________State__________ Pin Code________________________ Phone Number ________________________ Mobile Number________________________ Email ID ________________________

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

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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

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

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Do you wish to provide any other information? ☐(Yes) ☐(No), If 'Yes', specify

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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 ______________________________

Date_____________________ Name of Insured/Claimant_________________________

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