

CLAIM FORM
Saral Bharat Sookshma Udyam Suraksha
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 _____





A. DETAILS OF INSURED/CLAIMANT

Name as per policy _____ _____		
Address _____ _____ _____		
City _____	State _____	Pin _____
Code _____		
Contact Details		
Number _____	Phone Number _____	Mobile _____
Email ID _____		
Brief Description of Business /Office/Industry/Occupation _____ _____		
Limits of Indemnity under the Policy (Rs.) _____ _____		

SBI General Insurance Company Limited.  Registered and Corporate Office: 9th Floor, Wing A& B, Fulcrum, Sahar Road, Andheri (East), Mumbai – 400 099 | CIN: U66000MH2009PLC190546 |  Toll free: 18001021111 |  customer.care@sbigeneral.in |  www.sbigeneral.in | For more details on the risk factor, terms, and conditions, please refer to the Sales Brochure and Policy Wordings carefully before concluding a sale | SBI Logo displayed belongs to State Bank of India and used by SBI General Insurance Company Limited under license | IRDAI Reg No: 144 | UIN: IRDAN144RP0028V01202324

B. DETAILS OF LOSS/ACCIDENT





Date of Loss	____/____/____	Time of Loss	_____A.M. / P.M.
Loss Location			
Address	_____ _____ _____		
City	_____	State	_____
Code	_____	Pin	_____
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.)	(a) Building _____ (b) _____		

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P&M _____ (c)FFF _____

(d) Stocks _____ (e)
Others1 _____ (f)Others2 _____





WITNESS DETAILS	INFORMATION TO AUTHORITY
<p>Were there any witnesses to the loss / accident?</p> <p><input type="checkbox"/> (Yes) <input type="checkbox"/> (No), If 'Yes',</p> <p>Name of Person/s _____</p> <p>_____</p> <p>_____</p> <p>Address</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>City _____</p> <p>State _____</p> <p>Pin Code _____</p> <p>_____</p> <p>Phone Number</p> <p>_____</p> <p>_____</p> <p>Mobile Number _____</p> <p>_____</p> <p>Email ID</p> <p>_____</p>	<p>Has the loss been reported to an Authority <input type="checkbox"/> (Yes) <input type="checkbox"/> (No),</p> <p>If 'No', reason for not reporting _____</p> <p>If "Yes", provide details</p> <p><input type="checkbox"/> Fire <input type="checkbox"/> Police <input type="checkbox"/> Municipality <input type="checkbox"/> Other</p> <p>Name of Authority</p> <p>_____</p> <p>Information Report No./Authority Reference No. and Date</p> <p>_____</p> <p>_____</p> <p>Contact Person/s _____</p> <p>_____</p> <p>Address</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>City _____ State _____</p> <p>_____</p> <p>Pin</p>

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	Code _____ _____ Phone Number _____ _____ Mobile Number _____ _____ Email ID _____ _____

C. DETAILS OF OTHER INSURANCE

Is the loss/damage covered under any other Insurance <input type="checkbox"/> (Yes) <input type="checkbox"/> (No), If 'Yes', specify details and attach a copy of the policy
Name of Insurer: _____ _____
Address _____ _____
City _____ _____ State _____ PinCode _____ _____
Phone Number _____ _____ MobileNumber _____ EmailID _____

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Policy No. _____ Period of
Insurance _____ to _____

Sum Insured (Rs.) _____

D. DETAILS OF OTHER INTEREST

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 _____

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E. DETAILS OF PREVIOUS LOSSES

Losses during the 3 preceding years

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

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 _____

Date _____

Name of

Insured/Claimant _____

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