SBI General Insurance Company Limited

SBI general INSURANCE
SURAKSHA AUR BHAROSA DONO

Call (Toll Free)
1800 22 1111/ 1800 102 1111
www.sbigenerai.in

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

BROAD FORM LIABILITY CLAIM FORM

ISSUE OF THIS CLAIM FORM IS NOT TO BE TAKEN AS AN ADMISSION OF LIABILITY

Important Notice

- Please read this claim form fully before answering the questions.
- All questions must be answered as fully as possible. Please use additional sheets if necessary and copies of relevant documentation should be attached.
- Please send the completed claim form, as soon as possible to us
- Appointment of legal representatives should not occur without our prior consent.

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________________________

Insured's Business ______________________ Date of Last Premium Paid _________________________________

Limits of Liability 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____	____
Pin Code____	City __________________State__________________
Phone Number ___________________________________	Pin Code_____________________________________
Mobile Number___________________________________	Phone Number _______________________________
Email ID _______________________________________	Mobile Number________________________________
	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 ☐ Temporary

Is 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 ____

Give the details of Statute/ Law under which in your opinion liability may arise :

Give Full Details of the Accident including a sketch, if possible :

Sketch:

NEFT – ELECTONIC FUND TRANSFER - PAYMENT FORM – FOR CLAIMS DISBURSEMENT

(Please affix/staple the cancelled cheque here)

Full Name____
(As appears in your Policy/Bank account)

Contact no.(M)______________________________(T)_________________________________

Bank Name______________________________________ Branch_______________________

Bank Address____

Account No.___________________________________ IFSC code.______________________

MICR CODE ____________________

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: ____