SURAKSHA AUR BHAROSA DONO

Corporate 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.

PORTABLE - ELECTRONIC EQUIPMENT 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_____

A. DETAILS OF INSURED/CLAIMANT

Name as per policy_____

Address _____

_____

City_____State_____Pin Code_____

Contact Details

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

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

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_____