

CLAIM FORM
SBI General Bharat Griha Raksha

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 _____

Limits of Indemnity under the Policy (Rs.) _____





SBI General Insurance Company Limited.  Registered and Corporate Office: "Natraj" 301, Junction of Western Express Highway & Andheri Kurla – Road, Andheri (East), Mumbai – 400 069 | 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: IRDAN144RP0032V01202021

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

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Mobile Number _____ _____ Email ID _____ _____	_____ _____ City _____ State _____ _____ Pin Code _____ _____ Phone Number _____ _____ Mobile Number _____ _____ Email ID _____ _____
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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 _____

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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 _____