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INDUSTRIAL ALL RISK INSURANCE POLICY

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 No.	Claim No.							
Davis da filosomona	- F D D M M Y Y Y Y T- D D M M Y Y Y Y							

10	Tend of insurance from										
	A. DETAILS OF INSURED/C	LAIMANT									
1.	Name as per Policy	S U R N A M E									
2.	Address	Plot No/Door No. Building Name									
		Road Area									
		City Pincode									
		State State									
3.	Contact Details	Phone No. Mobile									
		E-mail Id									
4.	Brief Description of Business /Office/Industry/Occupation										
5.	Limits of Indemnity under the Policy (Rs.)										
	D DETAILS OF LOSS / AGE										
	B. DETAILS OF LOSS/ACCII	DENT									
1.	B. DETAILS OF LOSS/ACCID	DENT Time of Loss :									
	Date of Loss	D D M M Y Y Y Y Time of Loss : a.m./p.m.									
	Date of Loss	Time of Loss : a.m./p.m. Plot No/Door No. Building Name									
	Date of Loss	Time of Loss : a.m./p.m. Plot No/Door No. Building Name Area									
2.	Date of Loss	Plot No/Door No. Plot No/Door No. Building Name Area City Pincode									
2.	Date of Loss Loss Location Address	Plot No/Door No. Plot No/Door No. Building Name Area City Pincode									
2.	Date of Loss Loss Location Address Contact Details of person/s	Time of Loss : a.m./p.m. Plot No/Door No. Building Name Area City Pincode State at Loss Location									
2.	Date of Loss Loss Location Address Contact Details of person/s Name	Time of Loss : a.m./p.m. Plot No/Door No. Building Name Area City Pincode State at Loss Location									
2.	Date of Loss Loss Location Address Contact Details of person/s Name Relationship with Insured	Time of Loss : a.m./p.m. Plot No/Door No. Building Name City Pincode State To R N A M E M I D D L E N A M E F I R S T N A M E									
3.	Date of Loss Loss Location Address Contact Details of person/s Name Relationship with Insured	Time of Loss : a.m./p.m. Plot No/Door No. Building Name Road Area City Pincode State The No American Files To									
 3. 4. 	Date of Loss Loss Location Address Contact Details of person/s Name Relationship with Insured Contact Details Describe Cause of	Time of Loss : a.m./p.m. Plot No/Door No. Building Name Road Area City Pincode State The No American Files To									

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WIT	NESS DETAILS																												
1. Were there any witnesses to the loss/accident?											s [No)															
I	If 'Yes',																												
2. 1	Name as Person/s	S U	R	Ν	А	Μ	Е			Μ	1	D	D	L	E N	А	Μ	Е			F	I	R	S	Т	Ν	А	Μ	Е
3. A	Address	Plot No	o/Doo	or No	o. [Building	g Na	me												
		Road													Area														
		City													Pincode	е													
		State																											
4. (Contact Details	Phone	No.												Mobile														
		E-mail	ld [
INFO	ORMATION TO AUTHORIT	ΓΥ																											
1. H	Has the loss been reported t	o an Au	ıthorit	ty?															Yes	s [No)						
I	lf 'No', reason for not reporti	ing																											
I	lf 'Yes', provide details	Fi	ire			Pol	ice			М	unic	ipal	lity		Other														
2. 1	Name of Authority																												
	Information Report No./ Authority Reference No.														Date	D	D	Μ	Μ	Υ	Υ	Υ	Υ						
4. (Contact Person/s	S U	R	Ν	А	Μ	Е			Μ	1	D	D	L	E N	А	Μ	Е			F	I	R	S	Т	Ν	А	Μ	Е
5. A	Address	Plot No	o/Doo	or No). [Building	g Na	me												
		Road													Area														
		City													Pincode	е													
		State																											
6. (Contact Details	Phone	No.												Mobile														
		E-mail	ld [
С	. DETAILS OF OTHER INS	URANC	E																										
1. 1	s the loss/damage covered	under ar	ny oth	ner li	nsurc	ince	?												Yes	;		No)						
	f 'Yes', specify details and attach a copy of the policy																												
2. 1	Name of Insurer																												
3. <i>A</i>	Address	Plot No	/Doo	r No). [Building	g Na	me												
		Road													Area														
		City													Pincode	9													
		State																											
4. (Contact Details	Phone	No.												Mobile														
		E-mail	Id																										
5. F	Policy No.		L																								_		
6. F	Period of Insurance	From	D	D	М	М	Υ	Υ	Υ	Υ]		-	То	D D	Μ	Μ	Y	Υ	Υ	Υ								
7. 9	Sum Insured (Rs.)]							-							

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D. DETAILS OF OTHER INTEREST

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G. DETAILS OF CONSEQU	JENTIAL LOSS										
1. Whether any alteration has been made in the nature of business/occupation of premises after inception of Policy?											
If 'Yes', please give details											
2. Were the premises occupie	d at the time of loss?										
If 'No', un-occupied since (date)											
Details of Damage under Material Damage Section under IAR Policy:											
3. Name of Insurer											
4. Address	Plot No/Door No. Building Name										
	Road Area										
	City Pincode										
	State State										
5. Contact Details	Phone No. Mobile										
	E-mail ld										
6. Policy No.											
7. Period of Insurance	From D D M M Y Y Y Y T										
8. Sum Insured (Rs.)											
a) Building	b) P&M										
d) Stocks	e) Others 1 f) Others 2										
9. Occupation of premises at	the time of loss: Manufacturing Facility Warehouse Shop Office Dwelling										
10. Estimated Loss Material Do	amage (Rs.)										
a) Building	b) P&M c) FFF										
d) Stocks	e) Others 1 f) Others 2										
11. Period for which the busine	ess was interrupted due to Fire and Special Perils/MBD										
12. What was the annual turn-	over for the last financial year?										
13. What is the estimated redu	ction in turn-over due to interruption?										
14. What is the estimated loss	of Gross Profit due to interruption?										
15. Standing Charges/Expenses	s incurred for Loss Minimization, if any Rs										
16. Were there any person/orgo	anization, in your opinion, responsible for the loss?										
If 'Yes', please provide details along with contact numbers and address, if available (this information will be used only for investigation of this claim and source will not be divulged to the suspected party)											
17. What steps have been take	on to prevent recurrence of similar incidence?										
17. What steps have been taken to prevent recurrence of similar incidence?											
	The prevent recurrence of similar medicines.										

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Losses during the 3 preceding years

, j	Teceding years				<u> </u>
Date of Loss	(Claim Description and Cause of Loss	Val	ue of Loss (Rs.)	Insurer
G. DETAILS OF C	OTHER INFORMATI	ON			
Do you wish to provid				Yes	No
If 'Yes', specify					
I/We, the above nam	ed, do hereby, to the	e best of my/our knowledge and belie	ef, warrant the truth of the f	oregoing statemen	its in every respect; and I/We
		any further declaration, the Compo ment, my/our claim shall be absolut			
		rident, my/our claim shall be absolut ident shall be forfeited.	ely forfeited, and the Policy	shali be huli ana v	ola, and all rights to recover there
Place			Signature of Insured/Clai	mant	
Detai D D M			Name of Insurad/Claims		