



State Bank of India - Insurance Claim Form

A. Policy & Claim Details

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|--------------------|------------|
| Claim ID: | C12345 |
| Policy Start Date: | 2023-01-15 |
| Claim Date: | 2024-02-20 |

B. Insured Person Details

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|-----------------------|----------|
| Full Name: | John Doe |
| Age: | 45 |
| Gender: | Male |
| Premium Amount (INR): | 20000 |
| Sum Assured (INR): | 500000 |
| Annual Income (INR): | 750000 |


C. Insurance & Channel Details

| | |
|--------------------|-------------------|
| Insurance Channel: | RetailAgency |
| Policy Number: | POL123456789 |
| Product Type: | Health |
| Claim Reason: | Medical Emergency |

D. Contact Information

| | |
|----------------|---------------------------|
| Email Address: | johndoe@example.com |
| Phone Number: | 9876543210 |
| Address: | 123 Street, City, Country |

I hereby declare that the information provided is accurate to the best of my knowledge.

| | |
|--|-------|
| Signature:  | Date: |
|--|-------|