

This is an Internal document.

BUSINESS SHIELD - CLAIM FORM

The issue of this form is not to be taken as an admission of liability. If any detail or information is not readily available, please do not delay dispatch of this form and such particulars may be sent later.

Policy No. _____

Claim No. _____

A. INSURED

Name	_____		
Address line 1	_____	City	_____
Address line 2	_____		
Phone No.	_____	Mobile No.	_____
Business/Occupation	_____	Period of Insurance	From _ / _ / _ To _ / _ / _
Limits of Indemnity under the Policy	_____		

B. DETAILS OF LOSS

Date of Loss	_____ / _____ / _____	Time	_____ / _____ / _____	AM / PM																																																
LOSS LOCATION																																																				
Address line 1	_____																																																			
Address line 2	_____																																																			
City	_____	State	_____	Pin Code																																																
Phone No.	_____	Mobile No.	_____	Email																																																
Describe cause of Loss/Damage _____																																																				

DETAILS OF THEFT																																																				
Date of Discovery	_____ / _____ / _____																																																			
Item Lost (Year/Make/Model)	Original Purchase Value	Purchase Date	Value Claimed																																																	
<table border="1"> <thead> <tr> <th colspan="2">WITNESS DETAILS</th> <th colspan="2">INFORMATION TO AUTHORITY</th> </tr> </thead> <tbody> <tr> <td colspan="2">Is any witness available for accident / loss? Yes / No</td> <td colspan="2">Have any authority been informed about Accident/ Loss?</td> </tr> <tr> <td colspan="2">If "Yes", specify</td> <td colspan="2">Yes / No. If "Yes", specify</td> </tr> <tr> <td colspan="2">Name of the Witness _____</td> <td colspan="2">Name of the Authority _____</td> </tr> <tr> <td colspan="2">Address Line 1 _____</td> <td colspan="2">Contact Person _____</td> </tr> <tr> <td colspan="2">Address Line 2 _____</td> <td colspan="2">Authority reference no. _____</td> </tr> <tr> <td colspan="2">City _____</td> <td colspan="2">Address Line 1 _____</td> </tr> <tr> <td colspan="2">State _____</td> <td colspan="2">Address Line 2 _____</td> </tr> <tr> <td colspan="2">Pin Code _____</td> <td colspan="2">City _____ State _____</td> </tr> <tr> <td colspan="2">Phone No. _____</td> <td colspan="2">Pin Code _____</td> </tr> <tr> <td colspan="2">Mobile No. _____</td> <td colspan="2">Phone No. _____ Mobile No. _____</td> </tr> <tr> <td colspan="2">Email _____</td> <td colspan="2">Email _____</td> </tr> </tbody> </table>					WITNESS DETAILS		INFORMATION TO AUTHORITY		Is any witness available for accident / loss? Yes / No		Have any authority been informed about Accident/ Loss?		If "Yes", specify		Yes / No. If "Yes", specify		Name of the Witness _____		Name of the Authority _____		Address Line 1 _____		Contact Person _____		Address Line 2 _____		Authority reference no. _____		City _____		Address Line 1 _____		State _____		Address Line 2 _____		Pin Code _____		City _____ State _____		Phone No. _____		Pin Code _____		Mobile No. _____		Phone No. _____ Mobile No. _____		Email _____		Email _____	
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Phone No. _____		Pin Code _____																																																		
Mobile No. _____		Phone No. _____ Mobile No. _____																																																		
Email _____		Email _____																																																		

C. DETAILS OF OTHER INSURANCE

Is the Loss/damage covered under any other Insurance? If "Yes", specify details and attach copy of policy	Yes / No
Name of the Insurer	_____
Address line 1	_____
Address line 2	_____
City	_____
State	_____
Pin Code	_____
Phone No.	_____
Mobile No.	_____
Policy No.	_____
Email	_____
Period of Insurance	From _ / _ / _ To _ / _ / _
Amount of Insurance	_____

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C. DETAILS OF OTHER INTEREST

Is the insured sole owner of the proper? If "Yes", specify details	Yes / No
Name of insured interest _____	
Person/s who has interest on property _____	
His nature of interest _____	
Address Line 1 _____ State _____	
City _____ State _____ Pin Code _____	
Phone No. _____ Mobile No. _____ Email _____	

D. DETAILS OF PREVIOUS LOSSES

Claims lodged during the preceding 3 years		
Claim Year	Claim Description	Amount Rs.

E. DETAILS OF OTHER INFORMATION

Do you wish to provide any other information? If "Yes", specify details	Yes / No
If "Yes", specify _____	

Declaration

1. I/We agree to provide additional information to the Company if required. I/We are the above insured, and I/We guarantee the truthfulness of the above statement in every respect, to the best of my/our knowledge and belief, and if I/We have made any false or fraudulent statement, or have suppressed or concealed any material facts, the policy will be cancelled and all rights in respect of past or future claims will be reserved.
2. I/We understand that the Company reserves the right to verify & obtain my identity, address, facts and documents relating to the policy and claim with rating agencies, third parties or service providers.
3. I/We have read and understood the privacy policy of the Company at www.universalsompo.com and I/We unconditionally agree and bind myself/ourselves to all the terms and conditions of your privacy policy as amended from time to time.
4. I/We have received a list of documents with this claim form and have understood all the requirements to be fulfilled for scrutiny and processing of this claim and the Company shall not be responsible for any delay in scrutiny and processing/settlement of claim due to claimant's non-fulfilment of requirements including non-submission of the required documents/information as mentioned above.
5. I/We declare that the details of all persons having an interest in the property in respect of which the claim is being made are provided as per the proposal form or by way of an endorsement in the policy. Except as disclosed in this claim form, no claim for the same or similar loss has been made or lodged with any other insurance company.
6. I/We hereby give my/our consent to the Company to verify and obtain my/our identity/address proof/ bank details as well as the identity/address proof of the Insured / Beneficial Owner through Central KYC Registry or UIDAI or through any other modes for the purpose of undertaking KYC.

Place:

Signature:

Date:

Name of Insured:

Toll free: 1-800-22-4030 / 1800-200-4030. Email: contactclaims@universalsompo.com