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Universal Sampo General Insurance Co. Ltd.

Regd. Office & Corporate Office: 8th & 9th Floor (South Side), Commerz International Business Park, Oberoi Garden City Off Western Express Highway, Goregaon East, Mumbai 400063

FIDELITY GUARANTEE INSURANCE POLICY- CLAIM FORM (RETAIL)

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	_____ Pin Code _____
Address line 2	_____ State _____		
Phone No.	_____	Mobile No.	_____ Email _____
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	_____ <input type="checkbox"/>	State	_____ Pin Code _____ <input type="checkbox"/>
Phone No.	_____	Mobile No.	_____ Email _____
Describe cause of Loss/Damage	_____		
Estimated Loss (Rs.)	_____		

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 Authority _____
Name of the witness _____	Contact Person _____
Address line 1 _____	Authority reference no. _____
Address line 2 _____	Address line 1 _____
City _____	Address line 2 _____
State _____	City _____ State _____
Pin Code _____	Pin Code _____
Phone No. _____	Phone No. _____ Mobile 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	<input type="checkbox"/> Yes <input type="checkbox"/> 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 _____

Claim Form – Fidelity Guarantee Insurance Policy (Retail)

UIN - IRDAN134RP0025V01202223

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D. DETAILS OF OTHER INTEREST

Is the insured sole owner of the property? If "No", specify details Yes No

Nature of Insured interest _____

Person/s who has interest on property _____

His nature of interest _____

Address line 1 _____ Address line 2 _____

City _____ State _____ Pin Code _____

Phone No. _____ Mobile No. _____ Email _____

E. DETAILS OF THE DEFAULTING EMPLOYEE

Please reply fully to the following questions regarding the duties of the employee at the time of defalcation:

Name of Employee _____

Employee's Address as per records

Address line _____ Address line 2 _____

City _____ State _____ Pin Code _____

Phone No. _____ Mobile No. _____ Email _____

Date of Birth _____ Designation _____

Job responsibilities _____ Start Date of Employment __/__/

Is Employee Terminated? Yes No
 If "Yes", Date of Termination __/__/

Is the defaulting employee a member of a joint family, or does he hold any property, furniture or other effects? If "Yes", specify _____ Yes No

Do the employee has any near relatives? If "Yes" specify _____ Yes No

Name of the Contact person _____

Relative Address line _____

Relative Address line 2 _____

City _____ State _____ Pin Code _____

Phone No. _____ Mobile No. _____ Email _____

Has the Insured taken any action against the employee? Yes No
 If "Yes", state the nature of action taken _____

Was he allowed to pay out any amounts on Insured's behalf? Yes No
 If "Yes", specify authority for Payments / Receipts _____

Was he required to give printed receipts from a book with counterfoils? Yes No
 If "Yes", how often were the counterfoils examined and Daily Weekly Fortnight Monthly
 Quaterly Others (specify) _____

Specify counterfoil reconciliation by whom _____

Was money paid into bank by the defaulting employee? Yes No
 If "Yes", specify bank reconciliation by whom _____

Is employee allowed to retain balance? If "Yes", maximum retention balance allowed Rs. _____ Yes No

Does the Insured hold any other security from the employee? Yes No
 If "Yes", specify its nature and amount Rs. _____

Did the employee have charge of stocks? Yes No
 If "Yes", in what way did stocks reach his hand? _____

Was he allowed to issue stores or materials independently? Yes No
 If "Yes", who authorized these issues? _____

How often was the position of stocks handled by the employee checked? _____ When was the last check made? __/__/

How often were the Account Books/ Stock Books at the place of the defaulting employee's employment audited and by whom? _____

When was the last audit done? __/__/

Has the Insured any money, estate, or effects of the employee in his possession? Yes No
 If "Yes", give particulars with amounts _____

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F. DETAILS OF OTHER INFORMATION

Do you wish to provide any other information?	<input type="checkbox"/> Yes	<input type="checkbox"/> 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:

Date:

Signature of Insured

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