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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
<b>LOSS LOCATION</b>	
Address line 1 _____	
Address line 2 _____	
City _____	State _____ Pin Code _____
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 Yes No
If "Yes", specify	Accident / Loss? 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 _____

### 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)

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#### D. DETAILS OF OTHER INTEREST

Is the insured sole owner of the property? If "No", specify details		<input type="checkbox"/> Yes <input type="checkbox"/> 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 default:

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?		<input type="checkbox"/> Yes <input type="checkbox"/> 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 _____		<input type="checkbox"/> Yes <input type="checkbox"/> No
Do the employee has any near relatives? If "Yes" specify _____		<input type="checkbox"/> Yes <input type="checkbox"/> 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?		<input type="checkbox"/> Yes <input type="checkbox"/> No
If "Yes", state the nature of action taken _____		
Was he allowed to pay out any amounts on Insured's behalf?		<input type="checkbox"/> Yes <input type="checkbox"/> No
If "Yes", specify authority for Payments / Receipts _____		
Was he required to give printed receipts from a book with counterfoils?		<input type="checkbox"/> Yes <input type="checkbox"/> No
If "Yes", how often were the counterfoils examined and		<input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Fortnight <input type="checkbox"/> Monthly
		<input type="checkbox"/> Quaterly <input type="checkbox"/> Others ( specify ) _____
Specify counterfoil reconciliation by whom _____		
Was money paid into bank by the defaulting employee?		<input type="checkbox"/> Yes <input type="checkbox"/> No
If "Yes", specify bank reconciliation by whom _____		
Is employee allowed to retain balance? If "Yes", maximum retention balance allowed Rs. _____		<input type="checkbox"/> Yes <input type="checkbox"/> No
Does the Insured hold any other security from the employee?		<input type="checkbox"/> Yes <input type="checkbox"/> No
If "Yes", specify its nature and amount Rs. _____		
Did the employee have charge of stocks?		<input type="checkbox"/> Yes <input type="checkbox"/> No
If "Yes", in what way did stocks reach his hand? _____		
Was he allowed to issue stores or materials independently?		<input type="checkbox"/> Yes <input type="checkbox"/> 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?		<input type="checkbox"/> Yes <input type="checkbox"/> 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](http://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](mailto:contactclaims@universalsompo.com)