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MACHINERY BREAKDOWN INSURANCE POLICY (RETAIL) - CLAIM FORM

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 to. _____

Claim to. _____

A. INSURED

Name _____	
Address line 1 _____	City _____ PinCode _____
Address line 2 _____	State _____
Phone No. _____	Mobile No. _____ Email _____
Business/Occupation _____	Period of Insurance From ___/___/_____ To ___/___/_____
LimitsofIndemnityunderthePolicy _____	

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 _____		
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/ Contact _____
Address line 1 _____	Person _____
Address line 2 _____	Authority/ reference no. _____
City _____	Address line 1 _____
State _____	Address line 2 _____
Pin Code _____	City _____ State _____
Phone to. _____	Pin Code _____
Mobile to. _____	Phone to. _____ 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 _____
Landline No. _____	Mobile to. _____
Period of Insurance _____	Email _____
From / / To / /	Amount of Insurance _____

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D. DETAILS OF OTHER INTEREST

Is the insured sole owner of the property? If "No", specify/	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 to. _____ Mobile No. _____ Email _____		

E. DETAILS OF ITEMS AFFECTED

SL. No.	DESCRIPTION OF EQUIPMENT	MAKER NAME	YEAR OF MAKE	SL.NO./ MACHIN NO.	SUM INSURED RS.	DATE OF LAST MAINTENANCE	EXPIRY OF AMC/ WARRANT Y	COST OF REPAIRS REPLACEMENT

Has the affected equipment undergone any repairs previously? Yes No
 If "Yes", the nature of such repairs

Date of repair	Nature of repair	Parts affected	Cost of repair

F. DETAILS OF REPAIR

Is the repair being carried out In-house?	Yes	No
If "Yes", specify submit job-Work Estimates along with Pro-forma Invoices of Spare Parts to be replaced		
If "No", speci/ following details		
Name of the Repairer _____		
Name of the Contact person _____		
Address line 1 _____		
Address line 2 _____		
City _____ State _____ Pin Code _____		
Phone to. _____ Mobile No. _____ Email _____		

G. DETAILS OF PREVIOUS LOSSES

Claims lodged during the preceding 3 years	Yes	No
Claim Year	Claim Description	Amount Rs.

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H. DETAILS OF OTHER INFORMATION

Do you wish to provide any other information?	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: _____

Date: _____

Signature of Insured

Toll free: 1-800-12-4030. Helpline: 012-26748600. Email: contactclaims@universalsompo.com