SBI general INSURANCE
SURAKSHA AUR BHAROSA DONO

Call (Toll Free)
1800 22 1111 | 1800 102 1111
www.sbigeneral.in

GROUP PERSONAL ACCIDENT INSURANCE POLICY

Claim Form

Issuance of this form does not amount to admission of any liability or a waiver of any of the terms and conditions of the insurance contract. If any claim is in any manner dishonest or fraudulent, or is supported by any dishonest or fraudulent means or devices, whether by the Insured Person/Claimant or anyone acting on behalf of the Insured Person, then the benefits under this policy shall be void and all benefits payable under it shall be forfeited.

Policy No. Claim No.

Period of Insurance From D D M M Y Y Y Y To D D M M Y Y Y Y

A. DETAILS OF INSURED/CLAIMANT

1. Name of the Claimant SURNAME MIDDLENAME FIRSTNAME
2. Name of the Insured SURNAME MIDDLENAME FIRSTNAME
3. Relationship with Insured Designation (if applicable)
4. Date of Birth of Insured D D M M Y Y Y Y Gender Male Female Employee No.
5. Address
   Plot No/Door No. Building Name
   Road Area
   City District
   State Pincode
6. Contact Details
   Phone No. Mobile
   E-mail Id
7. Name and Address of Group Stamp of Group

B. DETAILS OF ACCIDENT/INCIDENCE

1. Date of Accident/Incidence D D M M Y Y Y Y Time of Loss : A.M. / P.M.
2. Cause of Accident/Incidence
3. Details of Accident/Incidence
4. Accident/Incidence Location Address
   City District
   State Pincode
5. Were there any witness to the Accident/Incidence? Yes No
   If 'Yes', provide details,
   Name of Witness
   Address of Witness
   Plot No/Door No. Building Name
   Road Area
   City District
   State Pincode
   Contact Details
   Phone No. Mobile
   E-mail Id
6. Is Witness relative of Claimant? Yes No

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C. INFORMATION TO POLICE AUTHORITY

1. Has the loss been reported to Police Authority? ☐ Yes ☐ No

If 'No', reason for not reporting

First Information Report No. Medico Legal Case (MLC) No.

Report Date D D M M Y Y Y Y

Address of Police Station
Plot No/Door No. Building Name
Road Area
City District
State Pincode

Contact Details
Phone No. Mobile
E-mail Id

2. Was the person moved to hospital immediately after the accident? ☐ Yes ☐ No
If 'Yes',
3. Name of Hospital

Address of Hospital
Plot No/Door No. Building Name
Road Area
City District
State Pincode

Contact Details
Phone No. Mobile
E-mail Id

4. Date of Admission D D M M Y Y Y Y Date of Discharge D D M M Y Y Y Y

D. DETAILS OF OTHER INSURANCE

1. Is the Accident/Incidence covered under any other Insurance? ☐ Yes ☐ No

If 'Yes', specify details and attach a copy of the policy

Name of Insurer Policy No.

Policy Issuance Office Location Sum Insured (Rs.)

Period of insurance From D D M M Y Y Y Y To D D M M Y Y Y Y

E. FOR WHICH BENEFIT DO YOU CLAIM? [PLEASE TICK (✓) THE APPROPRIATE BOX]

Benefit	Amount claimed	Benefit	Amount claimed
☐ Accidental Death		☐ Repatriation Benefit and Funeral Expenses	
☐ Permanent Total Disability (PTD)		☐ Adaptation Allowance	
☐ Permanent Partial Disability		☐ Family Transportation Allowance	
☐ Temporary Total Disability (TTD)		☐ Ambulance Cover	
☐ Accidental Medical Expenses-As Inpatient/Outpatient		☐ Broken Bones	
☐ Hospital Confinement Allowance		☐ Loss of Books/Spectacles/Damage to Bicycles of School Children	
☐ Child education Support		☐ Reimbursement of exam fees / school fees:	
☐ Loan Protector		☐ Purchase of Blood	
		TOTAL AMOUNT CLAIMED	

F. PAYEE DETAILS

1. Payable to ☐ Nominee ☐ Policyholder
2. Payment Mode ☐ Cheque ☐ NEFT

Bank Name | Bank Branch

Bank Account No. | IFSC Code

MICR No. | PAN No.

Note: It is agreed that the Policyholder/Claimant will intimate in writing to SBI General about any change in bank account details. Please attach a cancelled cheque pertaining to the same account.

G. ANY OTHER INFORMATION YOU MAY WISH TO PROVIDE

I/We, above named hereby authorise any hospital, physician, Police & statutory authorities, relevant witnesses and /or relatives or other person who has attended or examined the insured, to disclose when requested to do so by SBI General Insurance Co. Ltd. or its permitted and authorised representatives, any and all information including any medical records or other relevant information. A photocopy of this authorisation shall be considered as effective and valid as original instruction on my / our behalf.

I/We, the above named, do hereby, to the best of my/our knowledge and belief, warrant the truth of the foregoing statements in every respect; and I/We agree that if I/We have made, or make in any further declaration, the Company may require in respect of the said accident, any false or fraudulent statement, or any suppression or concealment, my/our claim shall be absolutely forfeited.

Place | Signature of Insured/Claimant

Date (D D M M Y Y Y Y) | Name of Insured/Claimant

ANNEXURE I: TO BE COMPLETED BY NOMINEE IN THE EVENT OF INSURED'S DEATH

1. Name of Nominee (SURNAME MIDDLE NAME FIRST NAME)
2. Relationship with Insured | Date of Birth (D D M M Y Y Y Y) | Sex ☐ M ☐ F
3. Address
   - Plot No/Door No. | Building Name
   - Road | Area
   - City | District
   - State | Pincode
4. Contact Details
   - Phone No. | Mobile
   - E-mail Id

If nominee is minor, kindly provide the Legal Guardian details

5. Name of Guardian (SURNAME MIDDLE NAME FIRST NAME)
6. Relationship with Insured | Date of Birth (D D M M Y Y Y Y)
7. Address
   - Plot No/Door No. | Building Name
   - Road | Area
   - City | District
   - State | Pincode
8. Contact Details
   - Phone No. | Mobile
   - E-mail Id

I/We hereby declare and warrant the truth of the foregoing particulars in every respect. I /We agree that if I/We have made or shall make false or untrue statement, suppression or concealment, my/our right to compensation shall be forfeited.

I/We also hereby declare that I am/we are accepting the amount in full discharge of your obligations under the policy to the Insured Person and /or his/her legal heirs. I/we will hold you indemnified in the event of any claim under this policy being made against you by any other person or persons.

Place | Signature

Date (D D M M Y Y Y Y) | Name of Nominee

ANNEXURE II: MEDICAL CERTIFICATE - TO BE FILLED BY TREATING DOCTOR

1. Name & Address of the Insured — SURNAME | MIDDLE NAME | FIRST NAME

2. Gender ☐ Male ☐ Female — Date of Birth / Age D D M M Y Y Y Y / ☐☐

3. Nature of the Accident/Incident and details of injuries sustained _____

4. Cause of Accident/Incident _____

5. Are the injuries:
   a) Solely due to Accident/Incident ☐ Yes ☐ No
   b) Traceable to any disease ☐ Yes ☐ No
   If 'Yes', give details _____
   c) Traceable to any previous injury ☐ Yes ☐ No
   If 'Yes', give details _____

6. Was insured under influence of drugs / alcohol / intoxicants at the time of accident? ☐ Yes ☐ No

7. Is the injured person suffering from any disease or injury which may have contributed to the accident or likely to aggravate his/her condition or delay improvement? ☐ Yes ☐ No

   If 'Yes', give details _____

   Details of Disablement _____

   Nature of Disablement
   a) Permanent Total Disablement ☐ Yes ☐ No
   b) Permanent Partial Disablement ☐ Yes ☐ No
   c) Temporary Total Disablement ☐ Yes ☐ No

   Details of Disablement _____

   Details of treatment given _____

8. According to you, how long should the injured person be confined to bed/house as the direct and sole consequence of the injury sustained? From D D M M Y Y Y Y To D D M M Y Y Y Y

9. During this period will the injured person be able to attend to his/her normal duties? ☐ Yes ☐ No

   If 'Yes', from D D M M Y Y Y Y

   If 'No', please state probable date of his / her being able to attend to his normal duties D D M M Y Y Y Y

I certify that I have examined the above named Insured, the above statements are correct and that the injured person is necessarily disabled by the accident referred to

Name of treating Doctor

Qualifications — Registration No.

Address

Contact Details — Phone No.

E-mail Id

Signature of the Doctor _____ Date D D M M Y Y Y Y

Stamp of the Doctor _____ Stamp of the Hospital _____

H. ENCLOSURES CHECKLIST

Please attach following documents and tick appropriate box. (Please attach documents as per benefit claimed and tick appropriate box)

1. **Accidental Death:**
- ☐ Claim Form duly filled & signed
- ☐ Claim Intimation
- ☐ Police Copy
- ☐ Copy of FIR (First Information Report) / Spot Panchnama / Inquest Panchnama
- ☐ Death Certificate
- ☐ Death Summary
- ☐ Post Mortem Report
- ☐ Original Legal Heir Certificate (in case nomination has not been filed by deceased)

2. **Permanent Total Disablement / Permanent Partial Disablement / Temporary Total Disablement:**
- ☐ Claim Form duly filled & signed
- ☐ Claim Intimation
- ☐ Police Copy
- ☐ Copy of FIR (First Information Report) / Spot Panchnama / Inquest Panchnama
- ☐ Photograph of the injured with reflecting disablement
- ☐ Disability Certificate from appropriate Government Authority
- ☐ Medical Certificate from treating Doctor
- ☐ Leave Certificate from the Employer
- ☐ Investigation Reports
- ☐ Treatment Papers

3. **Accidental Medical Expenses – As Inpatient / Outpatient:**
- ☐ Same as the documents of List – 2, plus Medical Certificate from treating Doctor
- ☐ Investigation report
- ☐ Treatment papers

4. **Hospital Confinement Allowance:**
- ☐ Claim Form duly filled & signed
- ☐ Claim Intimation
- ☐ Policy Copy
- ☐ Copy of FIR (First Information Report) / Spot Panchnama / Inquest Panchnama
- ☐ Discharge summary

5. **Child Education Support:**
- ☐ All documents of List – 1 or List - 2, plus
- ☐ Study Certificate from the school of the dependent child mentioning the parent's name

6. **Loan Protector:**
- ☐ All documents of List – 1 or List - 2, plus
- ☐ Loan Approval Letter
- ☐ Loan Due Statement
- ☐ Last EMI paid proof

7. **Repatriation Benefit and Funeral Expenses:**
- ☐ All Documents of List – 1, plus
- ☐ Original Legal Heir Certificate (in case nomination has not been filed by deceased)
- ☐ Original Bills and payment receipt of funeral expenses
- ☐ Original Bills and payment receipt of repatriation expenses

8. **Adaptation Allowance:**
- ☐ All documents of List - 2, plus
- ☐ Original Bills and payment receipt of Adaptation done
- ☐ Prescription of the doctor mentioning the indication for Adaption

9. **Family Transportation Allowance:**
- ☐ All documents of List – 1 or List - 2, plus
- ☐ Original Bills and payment receipt
- ☐ Proof of the immediate family member such as Ration Card

10. **Ambulance Cover:**
- ☐ All documents of List – 1 or List - 2, plus
- ☐ Original Bills and payment receipt for Ambulance use
- ☐ Treating Doctor's consultation indicating need of Ambulance

11. **Broken Bones:**
- ☐ Same as the documents of List – 2, plus
- ☐ X ray Confirmation Report
- ☐ X ray Film

12. **Loss of Books/Spectacles/Damage to Bicycles of School Children:**
- ☐ Same as the documents of List – 2, plus
- ☐ Original Bills and payment receipt Loss of Books
- ☐ Original Bills and payment receipt Spectacles
- ☐ Original Bills and payment receipt of repair of Damage to Bicycles of School Children

13. **Reimbursement of exam fees / school fees:**
- ☐ All documents of List – 1 or List - 2, plus
- ☐ Original Bills and payment receipt- exam fees/school fees
- ☐ Letter from school for absenteeism

14. **Purchase of Blood:**
- ☐ All documents of List – 1 or List - 2, plus
- ☐ Bills and payment receipt – Purchase of blood
- ☐ Blood bank label for utilized blood
- ☐ Prescription of the doctor mentioning the indication of need of blood transfusion

Note: The Company reserves the right to seek additional documents (including KYC documents) and information as and when necessary for processing of the claim.