SBI General Insurance Company Limited
IRDA Reg. No. 144 dated 15/12/2009 | CIN: U66000MH2009PLC190546

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 (For SBI & its Associate Bank Account Holders Only)

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
5. Address — Plot No/Door No. — Building Name
   Road — Area
   City — District
   State — Pincode
6. Contact Details — Phone No. — Mobile
   E-mail Id

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 — Pincode
5. Were there any witness to the Accident/Incidence? ☐ Yes ☐ No
   If 'Yes', provide details,
   Name of Witness
   Address of Witness — Pincode
   Contact Details — Phone No. — Mobile
   E-mail Id
6. Is Witness relative of Claimant? ☐ Yes ☐ No

Version 1.6, Aug 2014

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

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

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/INTEREST

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
☐ Accidental Death	

F. PAYEE DETAILS [Payable to Nominee (*All fields are mandatory)]

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. In case premium is issued from the same bank account through cheque, the cancelled cheque is not required.

G. ANY OTHER INFORMATION YOU MAY WISH TO PROVIDE

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 that the Company may require in respect of the said accident or any false or fraudulent statement, or any suppression or concealment, my/our claim shall be absolutely forfeited.

I/We hereby extend my/our consent to the Company for sharing my/our personal data with State Bank Group entities for specific purpose of availing services offered by State Bank Group(please strike this clause in case you do not wish to disclose the personal data).

Place Signature of Insured/Claimant

Date D D M M Y Y Y Y Name of Insured/Claimant

H. ENCLOSURES CHECKLIST

Accidental Death:

- ☐ Claim Form duly signed and attested by respective authorised SBI or its Associate Bank's official
- ☐ Original Certificate of Insurance
- ☐ Copy of Death Certificate attested by issuing authorities
- ☐ Copy of Final Police Report attested by issuing authorities
- ☐ Copy of FIR / MLC Copy / Spot Panchnama / Inquest Panchnama attested by issuing authorities
- ☐ Affidavit from the legal heirs of the deceased (in case nomination has not been filed by deceased)
- ☐ Copy of Post Mortem Report attested by issuing authorities
- ☐ Cancelled Cheque of Nominee

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

I. STATE BANK OF INDIA & ITS ASSOCIATE BANKS AUTHENTICATION

This is to certify that Mr / Ms _____ having account number _____

in _____ Branch, Branch Code _____ is / was covered under Group Personal Accident Master

Policy No. _____, Certificate No. _____ for Sum Insured Rs._____.

Nominee details which are provided above are valid as per our records. ☐ Yes ☐ No ☐ Not Applicable

The above information is true to best of my knowledge and we agree to provide any further information that may be required.

Place: | | | | | | | | | | | | | | | | |

Signature of Authorized Personnel: _____

Date: D D M M Y Y Y Y

Name of Authorized Personnel: _____

Bank Branch Seal:

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
3. Address | | 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 | | 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. Is death:
   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 / intoxicants / alcohol at the time of accident? ☐ Yes ☐ No

7. Was the insured suffering from any disease or injury which may have contributed to the accident or likely to aggravate his/her condition? ☐ Yes ☐ No

   If 'Yes', give details _____

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