

## ART INSURANCE CLAIM FORM

*Please note that the issue of this claim form is not to be taken as an admission of liability*

|                                                                    |                                                                                                                                                                                                                                                                                                    |  |  |  |  |  |  |  |  |    |  |    |  |  |  |  |  |  |  |  |  |  |
|--------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|--|--|--|--|--|--|----|--|----|--|--|--|--|--|--|--|--|--|--|
| Name of assured                                                    |                                                                                                                                                                                                                                                                                                    |  |  |  |  |  |  |  |  |    |  |    |  |  |  |  |  |  |  |  |  |  |
| Policy number                                                      |                                                                                                                                                                                                                                                                                                    |  |  |  |  |  |  |  |  |    |  |    |  |  |  |  |  |  |  |  |  |  |
| Policy Period                                                      | <table border="1" style="display: inline-table; border-collapse: collapse;"> <tr> <td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td> <td>to</td> <td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td> </tr> </table> |  |  |  |  |  |  |  |  |    |  | to |  |  |  |  |  |  |  |  |  |  |
|                                                                    |                                                                                                                                                                                                                                                                                                    |  |  |  |  |  |  |  |  | to |  |    |  |  |  |  |  |  |  |  |  |  |
| Date and Time of loss                                              | <table border="1" style="display: inline-table; border-collapse: collapse;"> <tr> <td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td> <td></td> </tr> </table>                                                                                              |  |  |  |  |  |  |  |  |    |  |    |  |  |  |  |  |  |  |  |  |  |
|                                                                    |                                                                                                                                                                                                                                                                                                    |  |  |  |  |  |  |  |  |    |  |    |  |  |  |  |  |  |  |  |  |  |
| Assureds /Correspondence Address                                   |                                                                                                                                                                                                                                                                                                    |  |  |  |  |  |  |  |  |    |  |    |  |  |  |  |  |  |  |  |  |  |
|                                                                    |                                                                                                                                                                                                                                                                                                    |  |  |  |  |  |  |  |  |    |  |    |  |  |  |  |  |  |  |  |  |  |
| Type of Loss                                                       |                                                                                                                                                                                                                                                                                                    |  |  |  |  |  |  |  |  |    |  |    |  |  |  |  |  |  |  |  |  |  |
| Brief description of Incidence                                     |                                                                                                                                                                                                                                                                                                    |  |  |  |  |  |  |  |  |    |  |    |  |  |  |  |  |  |  |  |  |  |
| Cause of Loss / Damage                                             |                                                                                                                                                                                                                                                                                                    |  |  |  |  |  |  |  |  |    |  |    |  |  |  |  |  |  |  |  |  |  |
| Details of witness (name, address, tel no's)                       |                                                                                                                                                                                                                                                                                                    |  |  |  |  |  |  |  |  |    |  |    |  |  |  |  |  |  |  |  |  |  |
| Approximate value of loss                                          |                                                                                                                                                                                                                                                                                                    |  |  |  |  |  |  |  |  |    |  |    |  |  |  |  |  |  |  |  |  |  |
| Section under which claim is preferred:                            |                                                                                                                                                                                                                                                                                                    |  |  |  |  |  |  |  |  |    |  |    |  |  |  |  |  |  |  |  |  |  |
| Details of FIR (if any)                                            |                                                                                                                                                                                                                                                                                                    |  |  |  |  |  |  |  |  |    |  |    |  |  |  |  |  |  |  |  |  |  |
| <b>DETAIL OF OTHER INSURANCES</b>                                  |                                                                                                                                                                                                                                                                                                    |  |  |  |  |  |  |  |  |    |  |    |  |  |  |  |  |  |  |  |  |  |
| Give details of other Insurance, if any, covering the present loss |                                                                                                                                                                                                                                                                                                    |  |  |  |  |  |  |  |  |    |  |    |  |  |  |  |  |  |  |  |  |  |
| <b>DETAILS OF PREVIOUS LOSSES</b>                                  |                                                                                                                                                                                                                                                                                                    |  |  |  |  |  |  |  |  |    |  |    |  |  |  |  |  |  |  |  |  |  |
| Give details of previous Claims, if any, on the project            |                                                                                                                                                                                                                                                                                                    |  |  |  |  |  |  |  |  |    |  |    |  |  |  |  |  |  |  |  |  |  |

## Declaration

I/We agree to provide additional information to the company, if required. I/We the above mentioned, do hereby, to the best of my/our knowledge and belief, warrant the truth of the foregoing statement in every respect, and if I/We have made, or in any further declaration the company may require in respect of the said accident, shall make any false or fraudulent statement, or any suppression or concealment, the policy shall be void and all rights to recover there under in respect of past or future accident shall be forfeited.

Date:

Place:

Signature of Assured:

Company Seal (for Dealers/ Galleries):

**Generali Central Insurance Company Limited (Formerly known as Future Generali India Insurance Company Limited) | Registered Office:** Unit No. 801 & 802, 8<sup>th</sup> Floor, Tower C, Embassy 247 Park, LBS Marg, Vikhroli (West), Mumbai – 400083 | **IRDAI Regn. No.:** 132 | **CIN:** U66030MH2006PLC165287 | **Website:** <https://generalicentralinsurance.com> | **Email ID:** [gcicare@generalicentral.com](mailto:gcicare@generalicentral.com) | **Toll-free Phone:** 1800 220 233 / 1860 500 3333/ 022 6783 7800