

FG PACK & PROTECT CLAIMS FORM

ISSUE OF THIS CLAIMS FORM IS NOT TO BE TAKEN AS AN ADMISSION OF LIABILITY

If any detail or information Is not readily available please do not delay the dispatch of this form and additional particulars may be sent later

The claim form is to be duly filled and signed by the insured. All facts and statements must be factual, and not influenced or biased in any favour.

If any detail or information is not readily available please do not delay the dispatch of this form and such particulars may be sent later.

Period of Insurance to	particulars may be sent later	•	
Claim Number	Policy Number		-
Geographical Limits A. DETAILS OF INSURED/CLAIMANT Name of the Insured	Period of Insurance	to	
A. DETAILS OF INSURED/CLAIMANT Name of the Insured	Claim Number		
Name of the Insured Address City State Pin code Contact details Phone Number Mobile Number Email ID Brief Description of Business / /Occupation/Profession Sum Insured under the Policy (Rs.)	Geographical Limits		
Address City State Pin code Contact details Phone Number Mobile Number Email ID Brief Description of Business / /Occupation/Profession Sum Insured under the Policy (Rs.)	A. DETAILS OF INSUI	RED/CLAIMANT	
Address City State Pin code Contact details Phone Number Mobile Number Email ID Brief Description of Business / /Occupation/Profession Sum Insured under the Policy (Rs.)	Name of the Insured		
City State Pin code Contact details Phone Number Mobile Number Email ID Brief Description of Business / /Occupation/Profession Sum Insured under the Policy (Rs.)			
Pin code Contact details Phone Number Mobile Number Email ID Brief Description of Business / /Occupation/Profession Sum Insured under the Policy (Rs.)	Tiddross	City	
Contact details Phone Number Mobile Number Email ID Brief Description of Business / /Occupation/Profession Sum Insured under the Policy (Rs.)		State	
Mobile Number Email ID Brief Description of Business / /Occupation/Profession Sum Insured under the Policy (Rs.)		Pin code	
Email ID Brief Description of Business / /Occupation/Profession Sum Insured under the Policy (Rs.)	Contact details	Phone Number	
Brief Description of Business / /Occupation/Profession Sum Insured under the Policy (Rs.)			
Business / /Occupation/Profession Sum Insured under the Policy (Rs.)		Email ID	
Sum Insured under the Policy (Rs.)			
Policy (Rs.)			
B. DETAILS OF LOSS/ACCIDENT	B. DETAILS OF LOSS/	ACCIDENT	
Date of Loss/ Time of LossA.M. / P.M.	Date of Loss/	Time of Loss	_A.M. / P.M.
Loss Location Address	Loss Location Address		
CityState			
Pin Code			
Please provide the details of the person who discovered the loss.			



Relationship with Insured				
Phone Number		Mobile Number		
	/Damage			
Estimated Loss (Rs.)				
Were there any witness		nt? (Yes) (No),		
Were there any witness If 'Yes',	ses to the loss / accider	nt? (Yes) (No),		
Were there any witness	ses to the loss / accider			
Were there any witness If 'Yes', Name of the Person's	ses to the loss / accider			
Were there any witness If 'Yes', Name of the Person's	ses to the loss / accider			
Were there any witness If 'Yes', Name of the Person's	ses to the loss / accider			
	ses to the loss / accider City State			
Were there any witness If 'Yes', Name of the Person's Address	Ses to the loss / accider City State Pin code Phone Number Mobile Number			
Were there any witness If 'Yes', Name of the Person's Address	City State Pin code Phone Number			
Were there any witness If 'Yes', Name of the Person's Address	City State Pin code Phone Number Mobile Number Email ID			
Were there any witness If 'Yes', Name of the Person's Address Contact details	City State Pin code Phone Number Mobile Number Email ID			
Were there any witness If 'Yes', Name of the Person's Address Contact details INFORMATION TO A	City State Pin code Phone Number Mobile Number Email ID AUTHORITY rted to an Authority?			
Were there any witness If 'Yes', Name of the Person's Address Contact details INFORMATION TO A	City State Pin code Phone Number Mobile Number Email ID AUTHORITY rted to an Authority? reporting			
Were there any witness If 'Yes', Name of the Person's Address Contact details INFORMATION TO A Has the loss been report If 'No', reason for not	City State Pin code Phone Number Mobile Number Email ID AUTHORITY rted to an Authority? reporting		□Other	

Claims Form_ FG Pack & Protect

UIN: IRDAN132RP0018V01202122

P a g e 2 | 4



per	
ber	
TCE ther Insurance (Y	Yes) (No),
by of the policy	
per	
ber	
To:	
ATION mation?(Yes) (No),	If 'Yes', specify

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 I/We agree that if I/We have made, or in any further declaration the Company may require in respect of the said loss/damage, any false or fraudulent statement, or any suppression or concealment, my/our claim shall be absolutely forfeited, and the Policy shall be void, and all rights to recover there under in respect of past or future loss/damage shall be forfeited.

Place	Signature	
Date	Name of Insured/Claimant	

UIN: IRDAN132RP0018V01202122