GENERALI Central INSURANCE

SAMPORNA SURAKSHA-GRIHA (MICRO INSURANCE)
-CLAIM FORM

Issue Of This Claim 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 such particulars may be sent later

1. Claim Number	
2. Policy Number	
3. Period of Insurance	From To
4. Type of coverage	Individual ☐ Group ☐
5. Name of the Insured (in whose name the policy is issued)	
6. Customer ID no.	
7. (a) Name of the claimant person (in respect of whom the claim is made)	
(b) Relationship to the Insured	
(c) Present completed age	
(d) Occupation	
(e) Residential Address	City State: Pin code:
8. Please give a full description of the event, the time, date, other parties involved, and any other relevant details	
9. Do you have any other insurance that may extend to cover your loss? If so, please provide details of the policy and the Insurer	
10. Cover under which claim is made (Please Tick and provide the details)	[ ] Hospital Cash [ ] Personal Accident [ ] Building and Contents [ ] Burglary and Robbery

	[ ] Farm Produce [ ] Agricultural Pump set [ ] Cart protection & Liability [ ] Pedal Cycle

SECTION 1: HOSPITAL CASH	
1. Nature of disease/ illness contracted or injury suffered or complete diagnosis	
2. Date of disease/ illness first detected	
3. Details of Pre existing disease/ illness with duration of disease/ illness (if any)	
4. Past history of disease/ illness with duration of disease/ illness (if any)	
5. (a) Name and address of attending medical practitioner	
(b) Qualification / Degree	
(c) Registration no	
(d) Contact No	
6. (a) Name and address of Hospital/ Nursing Home/ Clinic (where patient hospitalized or treatment taken)	
(b) Registration no of the Hospital	
(c) Date of admission	
(d) Date of discharge	

7. Nature of the claim (Please indicate by tick mark)			
(a) Type of Provider	Network ☐	Non network ☐	
(b) Type of admission	Emergency ☐	Planned ☐	Day Care ☐
In support of the above claim, I enclose following documents in Original			

(Note: All original documents will be returned back post verification) *(Please indicate by tick mark)*	
(a) Final Hospital Bill with Receipt	
(b) Discharge certificate/card from the Hospital	
(c) Attending Doctor's / Consultant's / Specialist's / Anesthetist's certificate regarding diagnosis.	
(d) Surgeon's certificate stating nature of operation performed and Surgeon's bill and receipt	

SECTION 2: PERSONAL ACCIDENT	
1. Please give the description of the loss	
2. Please give medical advice or treatment undertaken, and the Doctors certificates in original, if possible	
3. Death certificate /Post mortem report (if required	

SECTION 3: BUIDLING AND CONTENTS	
1. Date of loss & Time of Loss: am/pm	
2. Description the circumstances of Loss, how it happened, and what Caused Loss/Damage and details of the building	
3. Loss Location Address	City: State: Pin code:
4. Contact Details of person/s at Loss location	Name: Relationship with Insured: Contact Details: Phone No. Mobile No. Email Id:
5. Description of the Contents	
6. Nature of loss/ cause of loss	
7. In Case of Death : Please provide following details:	a. Name of Nominee: _____ _____ _____ b. Nominee's Mobile No. :

	_____ E Mail ID:_____ _____ *In case nominee has been declared at the time of proposal, then no change will be accepted at the time of claim. Legal Heir Certificate is mandatory if nominee details are not available in policy.
8. Your estimate of loss/ damage caused:	
9. Witness Details	Were there any witnesses to the loss/accident? Yes/No If Yes, Name as Person/s: Address: City: State: Pin code: Contact Details: Phone No. Mobile No. Email Id:
10. Information to Authority	Has the Loss been reported to an Authority? Yes/No If No, Reason for not reporting If Yes, Provide details: Fire/Police/Municipality/Other Name of Authority: Information report No./Authority reference no. Date: Contact Person/s Address: City: State: Pin code: Contact Details: Phone No. Mobile No. Email Id:
11. DETAILS OF OTHER INSURANCE	
Is the loss / damage covered under any other	Yes/No If Yes, specify details and attach a copy of the policy

insurance?	
Name of Insurer	
Address	City: State: Pin code:
Contact Details	Phone No. Mobile No. Email Id:
Policy No.	
Period of Insurance	From To
Sum Insured (rs.)	

12. DETAILS OF OTHERS INTEREST

Name of Insurer	
Is the Insured the Sole Owner of the property?	Yes/No If No, please specify
Nature of Interest	
Person/s who has/have Interest on property	
Address	City: State: Pin code:
Contact Details	Phone No. Mobile No. Email Id:

13. Please provide details of claim for property destroyed or damaged or lost Item no of the policy? (Please attach separate sheet if required)	

14. Details of Previous Losses

Losses during the 3 preceding years

Date of loss	Claim description and Cause of loss	Amount of loss (Rs.)	Insurer

15. Details of Other Information

Do you wish to provide any other information? □ Yes □No, If "Yes", specify

16. Please submit photographs of loss or physical damage, wherever possible.

SECTION 4: ROBBERY AND BURGLARY

1. Nature/ cause of loss	
2. Description of loss or damage including damage caused to locks if any	
3. Was the loss reported to the Police? If Yes, Case No.	
4. Has the perpetrator been apprehended by the Police?	
5. Where was the item lost located before such loss occurred?	
6. Was the item left unattended? **7. If yes, was the same locked or secured, as the case may be?**	

Item (please describe in detail)	Date Of manufacture	Owner	No of pieces	Destroyed/ damaged/ lost	Price paid

SECTION 5: FARM PRODUCE

1. Where was the farm produce kept at the time of the loss?	
2. Nature/ cause of loss	
3. Was there any ignitable or flammable substance kept in or around the farm produce at the time of the loss?	

4. What preventive measures were taken?	
5. Was an attempt made to salvage the damaged goods? If yes, details of the salvage?	
SECTION 6: AGRICULTURAL PUMPSET	
1. Year, make & manufacturer of the Pump Set	
2. Nature/ cause of loss	
3. Whether electrical or diesel?	
4. Where was the Pump Set located and what was it used for, before the loss?	
5. Was the pump set in good working condition?	
6. How old was the pump set?	
SECTION 7: CART PROTECTION & LIABILITY	
1. Damage to the Cart **(a) What was the time and date of the loss?** **(b) What was the precise nature in which the loss occurred?** **(c) Were any attempts made to minimize the loss?**	
2. Death or Permanent Total Disability of the Animal attached to the Cart **(a) Original copy of the Veterinary Practioner certifying either death or PTD** **(b) Were any attempts made to save the Animal**	
3. Death or Permanent Total Disability of the authorized driver of the Cart **(a) What was the nature of the accident?** **(b) What was the driver doing at the time of the accident?** **(c) What was the nature of the bodily injury sustained?** **(d) Was he given any medical**	

treatment, and if so with what results. Please furnish proof of medical treatment undertaken. (e) Death certificate/ Post mortem report (in case of death)	
4. Damages by a third party caused due to the accidental bodily injury or death of such third party (a) What was the nature of the accident? (b) What was the nature of the injuries sustained? (c) Was he given any medical treatment? Please furnish proof of medical treatment undertaken.	

SECTION 8: PEDAL CYCLE

1. Was the pedal cycle stolen or has there been loss of the accessories?	
2. Was the loss reported to the Police? If, Yes, Case No.	
3. Has the perpetrator caught by the Police?	
4. Where has been the pedal cycle located before the loss occurred?	
5. Was the pedal cycle unattended while it was lost?	
6. Was the same securely fastened and/ or locked while it was unattended?	
7. Have you been given notice of any claim or proceeding in regard to accidental death or bodily injury and accidental damage to property arising out of or connected with the pedal cycle?	

Date of manufacture	Owner	No. of pieces	Destroyed / Damaged/ Lost	Price paid

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 Insured/Claimant:

Name of Insured/Claimant:

**********END**********