IFFCO-TOKIO GENERAL INSURANCE CO. LTD
Regd. Office: IFFCO Sadan, C-1, Distt. Centre, Saket, New Delhi-110017

ADDRESS OF POLICY ISSUING OFFICE

Claim No.: _____ **Date of Issue:** _____

ALL IN ONE HOME PROTECTOR POLICY
UIN: IRDAN106RP0064V03201819

SECTION 1 - FIRE AND ALLIED PERILS CLAIM FORM

- Please note that this Claim Form is issued without prejudice to the terms and conditions of the policy and issuance of this form should not be construed as admission of Liability.
- Please fill in all the blanks and give complete details of information asked for. In case space provided is found insufficient, a separate sheet may kindly be annexed.
- Please return this form, duly filled & signed, within 15 days, from the date of occurrence.

Policy Number	
Insured Name	
Sum Insured under Section 1 (Fire and Allied Perils)	Part A – Contents : Part B – Building :
Date & Time of loss	
Location of Loss (Complete Address of Location)	
Circumstances of loss (Brief write up as to how the fire took place and how it spread, fire fighting efforts made and how finally it could be controlled)	
Your opinion about the Cause of Loss	

Estimate of Loss (Pls give details as per schedule)

S. No.	Description	Estimated Loss (in Rs)

Details of Other Existing Insurances

Name & Address of Company	Policy No.	Sum Insured

Kindly mention if there is any claim in below extensions –

1. Escalation Clause
2. Debris Removal
3. Professional Fees
4. Additional Rent/ Loss of Rent

S. No.	Extension	Description	Estimated Amount (in Rs)
1.	Escalation Clause		
2.	Debris Removal		
3.	Professional Fees		
4.	Additional Rent/ Loss of Rent	New address where house on Rent is taken	
		Amount of rent per month of new address	
		No. of months for which additional rent is paid	
		Rent per month of damaged house (in Rs.)	

DETAILS OF INSURED'S BANK ACCOUNT:

a) PAN | b) Account Number

c) Bank Name and Branch:

d) Cheque/ DD Payable details: | e) IFSC Code:

I/We, declare that all statements made on this form are true to the best of my/our knowledge and belief and that the articles and property described belong to the persons named, no other person having any interest therein, whether as Owner, Mortgagee Trustee or otherwise.

I/We agree that 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, my/our claim shall be absolutely forfeited, and the Policy shall be null and void.

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Name: **Signature:** **Date:**

IFFCO-TOKIO GENERAL INSURANCE CO. LTD

Regd. Office: IFFCO Sadan, C-1, Distt. Centre, Saket, New Delhi-110017

ADDRESS OF POLICY ISSUING OFFICE

Claim No.: _____ **Date of Issue:** _____

ALL IN ONE HOME PROTECTOR POLICY

UIN: IRDAN106RP0064V03201819

BURGLARY CLAIM FORM

Note: This claim form is applicable for Section 2 **– Burglary & Housebreaking Including Larceny or Theft and Other Perils** and Section 6C **– Pedal Cycle**

- Please note that this Claim Form is issued without prejudice to the terms and conditions of the policy and issuance of this form should not be construed as admission of Liability.
- Please fill in all the blanks and give complete details of information asked for. In case space provided is found insufficient, a separate sheet may kindly be annexed.
- Please return this form, duly filled & signed, within 15 days, from the date of occurrence.

Please tick the section in which the claim is preferred:

☐ **Section 2 – Burglary & Housebreaking Including Larceny or Theft and Other Perils**
☐ **Section 6C – Pedal Cycle**

Policy Number	
Insured Name	
Address for Correspondence	
Sum Insured under the Section	
Complete Address of Location of Loss	
Date and time of loss. When was the loss discovered and by whom	
How was entry to the premises affected?	
Has the police been notified? If so, by whom & when and at which Police Station. If not, please state the reason.	
Was the Insured house occupied at the Time of the loss? If not, please specify when it was last occupied? For how long, has the Insured house been unoccupied since the policy was effected or last renewed?	
Is anybody suspected of the theft/burglary? If so, please state full details.	
If there is no evidence of theft or of forcible entry of the	

premises, has a thorough search been made for the articles missing?	
Are you the sole owner of (i) the property lost or damaged? (ii) Of the premises? Are you responsible for repairs to premises?	
Have you ever before sustained loss by burglary, housebreaking or theft? (If so, please state particulars)	

Description of event:

Details of Other Existing Insurances

Name & Address of Company	Policy Number	Sum Insured

DETAILS OF INSURED'S BANK ACCOUNT:

a) PAN _____ ***b) Account Number*** _____

c) Bank Name and Branch: _____

d) Cheque/ DD Payable details: _____ ***e) IFSC Code:*** _____

I/We, declare that all statements made on this form are true to the best of my/our knowledge and belief and that the articles and property described belong to the persons named, no other person having any interest therein, whether as Owner, Mortgagee Trustee or otherwise.

I/We agree that 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, my/our claim shall be absolutely forfeited, and the Policy shall be null and void.

Name: Signature: Date:

Full description of articles stolen or property damaged	To whom the articles or property belonged	From whom purchased or received (Name and Address)	Date purchase or receipt	Value of the article of property
			Amount claimed	

IFFCO-TOKIO GENERAL INSURANCE CO. LTD

Regd. Office: IFFCO Sadan, C-1, Distt. Centre, Saket, New Delhi-110017

ADDRESS OF POLICY ISSUING OFFICE

Claim No.: _____ **Date of Issue:** _____

ALL IN ONE HOME PROTECTOR POLICY

UIN: IRDAN106RP0064V03201819

ALL RISK CLAIM FORM

Note: This claim form is applicable for Section 3 **– All Risk**, Section 4 **– Fixed Glass** and **Sanitary Fittings** and Section 10 **– Baggage**

- Please note that this Claim Form is issued without prejudice to the terms and conditions of the policy and issuance of this form should not be construed as admission of Liability.
- Please fill in all the blanks and give complete details of information asked for. In case space provided is found insufficient, a separate sheet may kindly be annexed.
- Please return this form, duly filled & signed, within 15 days, from the date of occurrence.

Please tick the section in which the claim is preferred:

☐ **Section 3 – All Risk**

☐ Part A- All Risks – Jewellery and Other Valuables ☐ Part B- All Risks – Fine Arts

☐ **Section 4 – Fixed Glass and Sanitary Fittings**

☐ **Section 10 – Baggage**

Policy Number	
Insured Name	
Sum Insured under the Section	
Date & Time of Loss	
Complete Address of Location of Loss	
Circumstances of loss (Brief write up on circumstances under which loss occurred & when it was detected)	
Your opinion about the Cause of Loss	
Item/s affected by loss (Please provide the complete list itemwise)	
Name of the Police Station	

FIR No. and date (Please enclose original or certified copy of FIR)	
Name of the Carrier/Authority in whose custody the loss has taken place (if applicable)	
Has the claim been lodged on the Carrier/Authority	
Date when the claim has been lodged on the Carrier/Authority (Please enclose copies of the correspondence exchanged with them)	
Extent of Damage	
Cost of Repair (attach copy of Quotation)	
Any other information which you would like to provide	

Details of Other Existing Insurances

Name & Address of Company	Policy Number	Sum Insured

DETAILS OF INSURED'S BANK ACCOUNT:

a) PAN _____ ***b) Account Number*** _____

c) Bank Name and Branch: _____

d) Cheque/ DD Payable details: _____ ***e) IFSC Code:*** _____

I/We, declare that all statements made on this form are true to the best of my/our knowledge and belief and that the articles and property described belong to the persons named, no other person having any interest therein, whether as Owner, Mortgagee Trustee or otherwise.
I/We agree that 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, my/our claim shall be absolutely forfeited, and the Policy shall be null and void.

Name: **Signature:** **Date:**

IFFCO-TOKIO GENERAL INSURANCE CO. LTD

Regd. Office: IFFCO Sadan, C-1, Distt. Centre, Saket, New Delhi-110017

ADDRESS OF POLICY ISSUING OFFICE

Claim No.: _____ **Date of Issue:** _____

ALL IN ONE HOME PROTECTOR POLICY

UIN: IRDAN106RP0064V03201819

SECTION 8 - PERSONAL ACCIDENT INSURANCE CLAIM FORM

1. Please note that this Claim Form is issued without prejudice to the terms and conditions of the policy and issuance of this form should not be construed as admission of Liability.
2. Please fill in all the blanks and give complete details of information asked for. In case space provided is found insufficient, a separate sheet may kindly be annexed.
3. In case of a death claim, please return this form duly completed together with Death Certificate from the Hospital or the Medical Attendant, Post Mortem Certificate, and Police Panchanama, if any, in;
4. Should there be delay in obtaining any documents relating to the claim, kindly return this Claim Form, duly filled and signed, first to Our Policy Issuing Office (mentioned in the Policy Schedule).

Policy No.	
Limits of Liability under the Policy	
Date & Time of Loss	
Name of Claimant (in full) [If more than one, state names of all] Full Postal Address Relationship of Claimant with the deceased (in case of a death claim)	
State the benefit under which the claim is preferred	
Particulars of the Insured Person i) Name (in full) ii) Postal Address iii) Occupation iv) Age at the time of the accident	
When did the accident happen? (Please give date and exact time) Where did the accident happen? Please give full description of the accident, its cause and injuries sustained State date, time and place of death (in case of a death claim)	

On which date did the claimant receive information with regard to the accident and from whom?	
Please give the names and addresses of two persons who witnessed the accident	
Was the Insured person free from infirmity at the time of accident? If not, give particulars. Was the Insured person under the influence of drugs or alcohol at the time of accident? Is the Claimant satisfied that the death was directly due to the accident? Please give the names and addresses of the Hospital, Clinic or Nursing Home where the Insured Person was treated after the accident. The Medical Practioner / Surgeon who attended on the Insured Person after the accident Regular Physician of the Insured Person, if any	
Does the Insured Person have any other Accident Insurance on his life? If so, state the name of the Insurer/s and amount/s claimed.	

I/We, declare that all statements made on this form are true to the best of my/our knowledge and belief.

I/We agree that 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, my/our claim shall be absolutely forfeited, and the Policy shall be null and void.

Signature of Witness

Name:

Address:

Place:

Signature of Claimant

Date:

IFFCO-TOKIO GENERAL INSURANCE CO. LTD

Regd. Office: IFFCO Sadan, C-1, Distt. Centre, Saket, New Delhi-110017

ADDRESS OF POLICY ISSUING OFFICE

Claim No.: _____ **Date of Issue:** _____

ALL IN ONE HOME PROTECTOR POLICY

UIN: IRDAN106RP0064V03201819

SECTION 9 - LOAN PAYMENT PROTECTION CLAIM FORM

1. **Please note that this Claim Form is issued without prejudice to the terms and conditions of the policy and issuance of this form should not be construed as admission of Liability.**
2. **Please fill in all the blanks and give complete details of information asked for. In case space provided is found insufficient, a separate sheet may kindly be annexed.**
3. **Please affix the duly filled and signed Personal Accident Insurance Claim Form along with this Claim Form.**
4. **Should there be delay in obtaining any documents relating to the claim, kindly return this Claim Form, duly filled and signed, first to Our Policy Issuing Office (mentioned in the Policy Schedule).**

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1. Insured details -

Policy No:
Name of Insured:
Address:
Sum Insured:

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2. Particulars of Injury/ sickness/ disease:

Details of injury/ sickness/ disease:
Name and address of Medical practitioner: (Kindly attach a copy of report provided by Medical practitioner)
Details of EMI:

Bank/ Financer name	Type of Loan	EMI start date	No. Of instalments	Frequency of EMI	EMI value (in Rs.)	Other Details (if any)

Total estimate of outstanding EMIs		
Details of Other Existing Insurances		
Name & Address of Company	Policy No.	Sum Insured

I/We, declare that all statements made on this form are true to the best of my/our knowledge and belief.

Name: **Signature:** **Date:**

IFFCO-TOKIO GENERAL INSURANCE CO. LTD

Regd. Office: IFFCO Sadan, C-1, Distt. Centre, Saket, New Delhi-110017

ADDRESS OF POLICY ISSUING OFFICE

Claim No.: _____ **Date of Issue:** _____

ALL IN ONE HOME PROTECTOR POLICY

UIN: IRDAN106RP0064V03201819

SECTION 11A - PUBLIC AND PERSONAL LIABIILTY CLAIM FORM

- Please note that this Claim Form is issued without prejudice to the terms and conditions of the policy and issuance of this form should not be construed as admission of Liability.
- Please fill in all the blanks and give complete details of information asked for. In case space provided is found insufficient, a separate sheet may kindly be annexed.
- Please return this form, duly filled & signed, within 15 days, from the date of occurrence.

1. (a) Name of Insured:

   (b) Address:

   (c) Policy Number:

   (e) Sum Insured under the Section:

2. Particulars of accident:

   (a) Date of occurrence:Time: _____ A.M./P/M.

   (b) Place of accident:

   (c) When did you first come to know of the accident?

   (d) When was the accident reported to you?

   (e) When was the claim first notified to the Insurer?

   (f) Name of the Insured Person liable to pay compensation to the third party

   (g) Relationship with the Insured

3. Particulars of consequences of the accident:

   (a) Has any person sustained any injuries in the accident? If so,

      (i) Give name/s, address/es and occupation/s of such person/s.

      (ii) State where such person/s was/were at the time of accident.

(iii) Have the injured persons been removed to hospital or medically attended? If so, give particulars.

(b) Has the accident caused damage to property or livestock? If so, give name/s and address/es of the owner/s of the property and/or livestock and full description of the property and state the nature of and extent of damage.

(c) Has any claim been made upon you by any person? If so, state by whom and give full particulars (if claim has been made in writing, attach a copy of the notification received and of the bill, if submitted).

(d) Has the insured incurred legal expenses in defending the claim?

(e) Is the Insured legally liable to pay Third party defense cost?

(f) Estimated amount of claim separately under (a), (b), (c), (d) and (e)

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4. (a) Give, if possible, the names and addresses of all witnesses to the accident.

(b) Has the accident been reported to any authority? If so, state to whom and attach a copy of the report submitted.

(c) What action, if any, has been taken by the authority?

(d) Give particulars of any other insurance, if any, in respect of the same risk.

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 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, my/our claim shall be absolutely forfeited, and the Policy shall be null and void.

Name: **Signature:** **Date:**

IFFCO-TOKIO GENERAL INSURANCE CO. LTD

Regd. Office: IFFCO Sadan, C-1, Distt. Centre, Saket, New Delhi-110017

ADDRESS OF POLICY ISSUING OFFICE

Claim No.: _____ **Date of Issue:** _____

ALL IN ONE HOME PROTECTOR POLICY

UIN: IRDAN106RP0064V03201819

SECTION 11 B - EMPLOYEES COMPENSATION INSURANCE CLAIM FORM

- Please note that this Claim Form is issued without prejudice to the terms and conditions of the policy and issuance of this form should not be construed as admission of Liability.
- Please fill in all the blanks and give complete details of information asked for. In case space provided is found insufficient, a separate sheet may kindly be annexed.
- Please return this form, duly filled & signed, within 7 days, from the date of occurrence. If any detail of information is not readily available PLEASE DO NOT DELAY DESPATCH of this form but send supplementary advice later.
- These questions are to be answered whether or not a claim from the injured person has been made or is anticipated.

PARTICULARS OF ACCIDENT TO BE FURNISHED BY THE EMPLOYER

PART – I THE EMPLOYER	
Name of Policy holder	
Policy Number	
Address	
District	
State & Pin Code	
PART – II PARTICULARS OF INJURED PERSON	
Name	
Religion or Caste	
Local Address	
Permanent Address	
Occupation in which injured person is employed	

On what work was injured person engaged at the time of accident?	
Was the injured person actually working when the accident occurred?	
Is injured person in your direct employment? (if not give name & address of Contractor and Nature of Contract)	
Name of the Hospital taken to	
State whether still in Hospital, or when discharged	

State nature of injury, body parts injured and whether left or right	
Did person actually cease work and if so, on what date ?	
Has injured person resumed duty since and if so, on what date?	
What is the probable period of disablement? (approximate)	
Was the injured person free from physical infirmity at the time of accident? If not, give particulars	
PART – III PARTICULARS OF ACCIDENT	
Date of Accident	
Did the accident occur actually within your home premises? If not, where did it occur?	
On what date did you receive notice of accident and from whom? If in writing please attach to this form	
Are you satisfied that injured person met with a bonafide accident of employment	
How exactly did the accident occur?	
If accident due to machinery, state: (a) Whether it was fenced or guarded (b) Was it being cleaned whilst in motion	
Was injured person under the influence of alcohol or drugs at the time of the accident?	
Was he guilty of misconduct or disobedience to orders or rules? If so, please give full particulars	
State through whose neglect, if any, it occurred	
State the names of any two persons who witnessed the accident	
Give names of overlooker or persons in Superintendence.	

I/We, declare that all statements made on this form are true to the best of my/our knowledge and belief.

I/We agree that 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, my/our claim shall be absolutely forfeited, and the Policy shall be null and void.

Name: **Signature:** **Date:**

STATEMENT OF INJURED PERSON'S EARNINGS

Statement of wages, which have fallen due for payment to _____
in the employment of _____ for 12 months prior to the date of his accident, or wages earned during such shorter period as he may have been in the employer's service.

Note: The object of this part of the form is to ascertain the extra average monthly earning of the injured person. It is essential that it should be carefully and correctly filled in. If the injured person has been in service for less than 12 months his date of entry into service is essential. So also if he was absent continuously for more than 14 days (within 12 months) between the date of his entry into service and that of accident, then the period of service should be counted from the date of resumption of duty.

Date on which injured person first entered service: _dd/mm/yyyy_____
Date on which the injured person resumed duty after a continuous absence of more than 14 days: _dd/mm/yyyy_____

Month & Year	Wages Earned (Including Overtime)		Value of bonus, food subsidy, if any, free quarters and any other allowance, etc.		Absences
1.	Rs.	P	Rs.	P	
2.					
3.					
4.					
5.					
6.					
7.					
8.					
9.					
10.					
11.					
12.					
Total earning in the period from_____ to _____					
Total earnings, including all allowances					
Monthly average wages					

SPECIAL NOTE :

1. If the employee's period of service was less than one month, give the average monthly wages of an employee employed on similar work Rs. _____.
2. Please state the exact nature of the allowance and / or bonus.
3. In the column "absence", please give the date of going on leave or beginning of period of absence and also date of subsequent resumption of work.

I/We, the undersigned, confirm that above given details are true & correct to the best of my/our knowledge.

Date: _____

Signature of Employer

(add below any additional information available regarding the accident)

_____

Signature of Employer

IFFCO-TOKIO GENERAL INSURANCE CO. LTD

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ADDRESS OF POLICY ISSUING OFFICE

Claim No.: _____ **Date of Issue:** _____

ALL IN ONE HOME PROTECTOR POLICY

UIN: IRDAN106RP0064V03201819

SECTION 11C - TENANTS LIABILITY CLAIM FORM

- Please note that this Claim Form is issued without prejudice to the terms and conditions of the policy and issuance of this form should not be construed as admission of Liability.
- Please fill in all the blanks and give complete details of information asked for. In case space provided is found insufficient, a separate sheet may kindly be annexed.
- Please return this form, duly filled & signed, within 15 days, from the date of occurrence.

Policy Number	
Insured Name	
Sum Insured under the Section	
Date & Time of Loss	
Complete Address of Location	
Circumstances of loss (Brief write up as to how the incident took)	
Your opinion about the Cause of Loss	

Details of Other Existing Insurances

Name & Address of Company	Policy No.	Sum Insured

Estimate of Loss (Give details as per schedule)		
S. No.	Description	Estimated Loss (in Rs)

DETAILS OF OWNER/LANDLORD'S BANK ACCOUNT:

a)Name of the landlord:

b) PAN ***c) Account Number:***

d) Bank Name and Branch:

e) Cheque/ DD Payable details: ***f) IFSC Code:***

I/We, declare that all statements made on this form are true to the best of my/our knowledge.

I/We agree that 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, my/our claim shall be absolutely forfeited, and the Policy shall be null and void.

Name: **Signature:** **Date:**

IFFCO-TOKIO GENERAL INSURANCE CO. LTD

Regd. Office: IFFCO Sadan, C-1, Distt. Centre, Saket, New Delhi-110017

ADDRESS OF POLICY ISSUING OFFICE

Claim No.: _____ **Date of Issue:** _____

ALL IN ONE HOME PROTECTOR POLICY

UIN: IRDAN106RP0064V03201819

SECTION 12 - INCREASED LIVING EXPENSES CLAIM FORM

- Please attach this claim form with the duly filled Section 1 (Fire and Allied Perils) or Section 2 (Burglary and Other Perils) claim form, whichever is applicable.
- Please note that this Claim Form is issued with out prejudice to the terms and conditions of the policy and issuance of this form should not be construed as admission of Liability.
- Please fill in all the blanks and give complete details of information asked for. In case space provided is found insufficient, a separate sheet may kindly be annexed.
- Please return this form, duly filled & signed, with in 15 days, from the date of occurrence.

Policy Number	
Insured Name	
Sum Insured under the Section	
Date & Time of loss	
Location of Loss (Complete Address of Location)	

Estimate of Expenses incurred for :	
i) Cost of evacuation of You, Your Family and Your domestic employees	
ii) Emergency medical treatment cost at home or at clinic/ hospital	
iii) Cost of hiring furniture and other household or electrical fittings and gadgets being utilised in Your Home	
iv) Cost of removal /transportation of Your Home Contents to the alternative accommodation	
v) Any emergency accommodation at a hotel, guest house or lodge	
vi) Daily food, clothing,shelter and consumer durable items	
vii) Reasonable legal cost in discharging your mortgage following the settlement of a total loss claim	

Details of Other Existing Insurances

Name & Address of Company	**Policy Number**	**Sum Insured**

DETAILS OF INSURED'S BANK ACCOUNT:

a) PAN _____ b) Account Number _____

c) Bank Name and Branch: _____

d) Cheque/ DD Payable details: _____ e) IFSC Code: _____

I/We, declare that all statements made on this form are true to the best of my/our knowledge and belief.I/We agree that 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, my/our claim shall be absolutely forfeited, and the Policy shall be null and void.

Name: **Signature:** **Date:**