



IFFCO TOKIO GENERAL INSURANCE CO. LTD.

Regd. Office: IFFCO Sadan, C-1, Distt. Centre, Saket, New Delhi 110 017

Comprehensive Property All Risk Policy

Claim Form

UIN – IRDAN106CPPR0004V01202526

Section 1A: Material Damage

Claim No.: _____

Policy No.: _____

- 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.

Date & Time of loss	
Location of Loss (Complete Address of Location)	
Circumstances of loss (Brief write up as to how the loss took place and efforts made to control the loss)	
Your opinion about the Cause of Loss	

Estimate of Loss (Give details as per schedule)					
Sr. No.	Block Name	Building	P & M	Stocks	Packing Material

Details of Other Existing Insurances		
Name & Address of Company	Policy No.	Sum Insured

I / We hereby declare that the statements made by us in the claim form are true to the best of our knowledge and belief and that we have not withheld any material information which has a bearing upon the claim.

Name:

Designation:

Signature:

Date:

Place:



IFFCO TOKIO GENERAL INSURANCE CO. LTD.

Regd. Office: IFFCO Sadan, C-1, Distt. Centre, Saket, New Delhi 110 017

Comprehensive Property All Risk Policy Section 1B: Machinery Breakdown Claim Form

Claim No. _____

Policy No.: _____

- 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 submit this form, duly filled & signed, within 15 days, from the date of occurrence.

1	Name & Address of Insured	
2	Email ID: Telephone Numbers (O) Telephone Numbers (R)	Available bet. _____ hrs to _____ hrs Available bet. _____ hrs to _____ hrs
3	Policy Number	
4	Period of Insurance	
5	Description of Item affected Make / Model / Year of Mfr.	
6	Serial No. of item in schedule	
7	Identification No. of item	
8	Date of Loss / accident / incident	
9	Was the item used as prescribed by the manufacturer?	
10	Circumstance of Loss (Brief write up on circumstances under which the equipment broke down and how & when it was detected)	
11	Your opinion about the cause of loss	
12	Location of item at the time of loss	
13	Where can it be examined now?	
14	Has item been dismantled?	
15	Is item covered under any A.M.C.?	
16	Is the item under warranty?	
17	Extent of damage / loss	
18	Estimated amount for repair / Quote if any.	
19	Increased Cost of working (if applicable); specific details of the increased cost likely to be incurred may please be provided	
20	Details of Other Existing Insurances	
	Name & Address of Company	Policy No.
		Sum Insured

I / We hereby declare that the statements made by us in the claim form are true to the best of our knowledge and belief and that we have not withheld any material information which has a bearing upon the claim.

Name:

Designation:

Signature:

Date:

Place:



IFFCO TOKIO GENERAL INSURANCE CO. LTD.

Regd. Office: IFFCO Sadan, C-1, Distt. Centre, Saket, New Delhi 110 017

Comprehensive Property All Risk Policy Section 2: Business Interruption Claim Form

Claim No.: _____

Policy No.: _____

- 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 No.		
Date & Time of loss		
Location of Loss (Complete Address of Location)		
Number of days for which your Business remained Interrupted		
Standard Turnover		
Reduction in Turnover (estimated)		
Estimate of Loss (should contain monetary value of loss):		
Steps taken by you to reduce the impact of Business Interruption:		
Did the loss occur because of failure of electricity supply/public utility (please give details)		
Did the loss arise out of a fire and/or allied perils (please give details)		
Did the loss arise out of a fire and/or allied perils at customers'/suppliers premises (please give details)		
Details of Other Existing Insurances		
Name & Address of Company	Policy No.	Sum Insured
Any other information which you may like to give:		

I / We hereby declare that the statements made by us in the claim form are true to the best of our knowledge and belief and that we have not withheld any material information which has a bearing upon the claim.

Name:

Designation:

Signature:

Date:

Place:



IFFCO TOKIO GENERAL INSURANCE CO. LTD.

Regd. Office: IFFCO Sadan, C-1, Distt. Centre, Saket, New Delhi 110 017

Comprehensive Property All Risk Policy Section 4: Money Claim Form

Claim No.: _____

Policy No.: _____

- 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 (in full) (b) Address (c) Business	(a) (b) (c)
2.(a) Date and time of occurrence of loss. (b) Date of discovery of loss. (c) What were the places between which money was in transit? (d) Where did the loss occur? (e) By whom was the loss reported? (A copy of written statement to be attached).	(a) (b) (c) (d) (e)
3.(a) in whose custody was the money at the time of the loss? (b) Who were the other persons accompanying the person carrying the money? (c) Did armed guards with fire arms accompanying the money? (d) How many persons accompanied him?	(a) (b) (c) (d)
4. Brief details as to the exact circumstances under which the loss occurred.	
5.(a) How was the money carried? (whether in pocket, bag, box etc.) (b) whether such bags, boxes, etc. were securely locked? (c) By what conveyance was the money carried?	(a) (b) (c)
6.(a)What was the amount of money being carried? (b) Was the total amount checked at the time of handing it over to the messenger? (c) Was any acknowledgement received from him.	(a) (b) (c)
7. What was the amount of loss?	
8. Has a complaint been made to the Police? If so, attach a copy thereof, If not, this may be done immediately.	
9.What steps have been taken to recover the lost money?	
10.(a)When did the employee concerned enter your service? (b)Was any one of them involved in a similar	(a) (b)

loss before? (c) Are you satisfied the version given by them is correct? (d) Are any of them covered under any Fidelity Guarantee Policy? If so, give details. (e) Do you hold any cash deposit or any other security from them?	(c) (d) (e)
11. Have you ever before sustained a loss of this nature? If so give particulars	
12. Are there any other insurances upon the same money? If so, give particulars.	

I / We hereby declare that the statements made by us in the claim form are true to the best of our knowledge and belief and that we have not withheld any material information which has a bearing upon the claim.

Name:

Designation:

Signature:

Date:

Place:



IFFCO TOKIO GENERAL INSURANCE CO. LTD.

Regd. Office: IFFCO Sadan, C-1, Distt. Centre, Saket, New Delhi 110 017

Comprehensive Property All Risk Policy Section 5: Fidelity Claim Form

Claim No.: _____

Policy No.: _____

- 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 No.	
Name of Insured (in full) Address Business	
Name of the defaulting employee in full. His Present address.	
Amount of Loss sustained.	
Date of Discovery of defalcation	
Date(s) defalcation	
How exactly was the defalcation committed? If space is not sufficient, please give full and detailed particulars on a separate signed sheet. Also, please attach a certified statement containing an entries in the Insured's books of accounts relative to the defalcation in the order of their dates)	
Please reply fully to the following questions regarding the duties of the employee at the time of defalcation: In what capacity was he engaged and where? In what way did money reach his hands? What was the largest sum which he had in his hands at any one time and for how long? Was he allowed to pay out any amounts on the Insured's behalf? Who authorised these payment or issue?	

<p>Was she required to give printed receipts from a book with counterfoils? If so, who often were the counterfoils examined and checked and by whom?</p> <p>Were moneys paid into Bank by the defaulting employee? If so how often were Bank Books examined and checked and by whom?</p> <p>What balance, if any was allowed to be kept in his hand?</p> <p>How often were his Cash Accounts balanced and how was their accuracy checked? Please explain fully.</p> <p>How often were accounts sent direct to Customers independently of the employee?</p> <p>Did the employee have charge of stock? If so in what way did stock reach his hands.</p> <p>Was he allowed to issue stores or materials independently? If not who authorised these issues?</p> <p>How often was the position of stock handled by the employee checked.</p> <p>When was the last check made?</p>	
How often were the Account Books/Stocks books at the place of the defaulting employee's employment audited and by whom? When was the last audit done?	
Has the Insured any money's estate, or effects of the employee in his possession? If so give particulars with amounts.	
Does the insured hold any other security from the employee? IF so state its nature and amount.	
Is the defaulting employee a member of a joint family, or does he holds any property furniture or other effects? If so, give details.	
Has the employee and near relatives? If so, give their names and addresses, if known.	
Has the Insured taken any action against the employee? If so, state the nature of action taken.	
Has the loss been reported to the Police? If so, state at which Police Station and what action, if any has been taken by them.	

I / We hereby declare that the statements made by us in the claim form are true to the best of our knowledge and belief and that we have not withheld any material information which has a bearing upon the claim.

Name:

Designation:

Signature:

Date:

Place:



IFFCO TOKIO GENERAL INSURANCE CO. LTD.

Regd. Office: IFFCO Sadan, C-1, Distt. Centre, Saket, New Delhi 110 017

Comprehensive Property All Risk Policy Section 6: Public Liability Claim Form

Claim No.: _____

Policy No.: _____

- 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 Particulars	
Policy No.	
Period of Insurance	
Name of Insured (in full) Address	
Business	
Limits of Indemnity under the Policy:	
Particulars of accident:	
Date of occurrence	Time: _____ A.M./P.M.
Place of accident:	
When did you first come to know of the accident?	
When was the accident reported to you?	
When was the claim first notified to the Insurer?	
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) Estimated amount of claim separately under (a), (b) and (c)	
Other Details	
Give, if possible, the names and addresses of all witnesses to the accident.	
Has the accident been reported to any authority? If so, state to whom and attach a copy of the report submitted.	
What action, if any, has been taken by the authority?	
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:

Designation:

Signature:

Date:

Place:



IFFCO TOKIO GENERAL INSURANCE CO. LTD.

Regd. Office: IFFCO Sadan, C-1, Distt. Centre, Saket, New Delhi 110 017

Comprehensive Property All Risk Policy Section 3: Accompanied Baggage Claim Form

Claim No.: _____

Date of Issue: _____

- 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 Particulars	
Policy No.	
Period of Insurance	
Name of Insured (in full)	
Address	
Date of loss	
Item/s affected by loss:	
Brief Description of loss:	
Cause of loss:	
Has the matter been reported to the Police?	
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)	
Estimate of loss (with complete breakup)	
Any other information which you would like to provide	

I / We hereby declare that the statements made by us in the claim form are true to the best of our knowledge and belief and that we have not withheld any material information which has a bearing upon the claim.

Name:

Designation:

Signature:

Date:

Place: