IFFCO-TOKIO GENERAL INSURANCE CO. LTD

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

Claim No:

INDUSTRY PROTECTOR INSURANCE POLICY-LAGHU UDYAM
UIN: IRDAN106CP0003V01202122
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 30 days, from the date of it's issuance.

INSURED'S DETAILS (Please fill all the details in CAPITAL Letters)

Policy No.					
Date and time of loss					
Complete risk location address.					
City		State		Pin Code	
Contact Person's name			Mobile No.		
Designation			Email Address		
Telephone no. (O) (Landline)	Availability between - ___ hrs to ___hrs		Telephone no. (R) (Landline)	Availability between - ___ hrs to ___hrs	

Nature of Insured Event and Claim Amount

Details of Incident – Material Damage Claim

Circumstances of loss (Brief details as to how loss look place and how it spread, how loss minimization efforts made & how finally if could be controlled)	
Was the premises occupied at the time of loss?	
Your Opinion about the cause of loss	

Fire Insurance Claim - Estimate of Loss (Please provide details as per schedule)					
S No.	Block Name	Building	Plant & Machinery	Stocks	Packing Material

Circumstances of loss (Brief details as to how loss look place and how it spread, how loss minimization efforts made & how finally if could be controlled)	
Was the premises occupied at the time of loss?	
Your Opinion about the cause of loss	

Description of Item affected (Plant & Machinery)	
Make / Model/ Year of Mfg.	
Serial No of item if any	
Identification No of Item	
Was the Item used as prescribed by the Manufacture?	
Where can it be examined now?	
Has item been dismantled?	
Is Item covered under any A.M.C	
Is Item under warranty?	
Extent of damage / Loss	
Estimated amount for repair / Quote if any	

Details of other Existing Insurances			
Name & Address of Insurance Company	Policy No	Sum Insured	Policy Expiry date

DECLARATION

I hereby declare that the information furnished in this claim form is true & correct to the best of my knowledge and belief. If I have made any false or untrue statement, suppression or concealment of any material fact with respect to questions asked in relation to this claim, my right to claim reimbursement shall be forfeited. I hereby declare that I have included all the documents for the purpose of this claim.

Date

Signature of the claimant

Place:

Name of the claimant

Burglary & Allied Perils Claim Form

(The issue of this form does not constitute admission of liability. Please return the form completed within Fourteen days of the loss together with the relevant vouchers etc.)

Claim No……

Policy No……..…….

1.(a) Name of Insured (in full) (b) Address © Business	(a) (b) (c)
2.(a) Describe the nature of loss along with date / time of occurrence of the loss. (b) Date of discovery of loss? © Address of the premises where loss occurred? (d) How was the premises occupied? (e) If not occupied when was it last occupied. (f) By whom was the loss reported? (A copy of written statement to be attached).	(a) (b) © (d) (e) (f)
3.(a) How did the loss occur? (b)If due to impact damage what caused the	3.(a)

object to fall? (c) If due to burglary, how was entry/exit to the premises done? (d) Are you responsible for repair to premises? (e) How many persons were involved? (f) Do you suspect anyone? If so give details.	(b) © (d) (e) (f)
4.(a) Has complaint been lodged with the Police? If so, by whom & when at which Police Station? (b) Please attach a copy of the Police Complaint © If not reported, please do so immediately and copy given to us. ?	4(a) (b) ©
5. State the amount of loss & the total value of Building & Contents at the time of the loss?	5.
6.What steps have been taken to minimize the loss?	6.
7. Have you ever before sustained a loss of this nature? If so give particulars	7.
8. Are there any other insurances upon the same assets? If so, give particulars.	8.

I/We hereby declare that the foregoing particulars are true and correct in every respect.

Place:

Date Signature of Insured.

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MACHINERY BREAK DOWN CLAIM FORM

Claim No.: _____
Date of Issue: _____

- 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 14 days, from the date of occurrence.

Policy No.	
Date & Time of breakdown	
Machine which broke down was installed at (Complete Address of Location)	
rcumstances of loss (Brief write up on circumstances under which machine broke down and how & when it was detected)	
Your opinion about the Cause of Breakdown	
Schedule Item of Policy	
Description of Machine	
Specification of Machine	
Extent of Damage	

Cost of Repair (attach copy of Quotation)		
Details of Other Existing Insurances		
Name & Address of Company	Policy No.	Sum Insured

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

Name: Signature: Date:

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EEI Claim Form

Electronic Equipment Insurance Claim Form ITGI/ENGG-EEI/07

Issue of this claim form does not constitute 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 14 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	Period of Insurance
4	Description of Item affected Make / Model / Year of Mfr.	
5	Serial No. of item in schedule	
6	Identification No. of item	
7	Date of Loss / accident / incident	Time
8	Was the item used as prescribed by the manufacturer?	
9	Circumstance of Loss (Brief write up on circumstances under which the equipment broke down and how & when it was detected)	
10	Your opinion about the cause of loss	
11	Location of item at the time of loss	
12	Where can it be examined now?	
13	Has item been dismantled?	
14	Is item covered under any A.M.C.?	
15	Is the item under warranty?	
16	Extent of damage / loss	
17	Estimated amount for repair / Quote if any.	
18	Loss to External Data Media (if applicable); please list out the type of data lost and the way the same is being replaced/reconstructed	
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 up on the claim.

Place :

Date : Signature of the Claimant

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MONEY INSURANCE CLAIM FORM

(The issue of this form does not constitute admission of liability. Please return the form completed within Fourteen days of the loss together with the relevant vouchers etc.)

Claim No…… Policy No……..…….

1.(a) Name of Insured (in full) (b) Address © Business	(a) (b) (c)
2.(a) Date and time of occurrence of loss. (b) Date of discovery of loss.	(a) (b)

© What were the places between which money was in transit? (g) Where did the loss occur? (h) By whom was the loss reported? (A copy of written statement to be attached).	© (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? ©Did armed guards with fire arms accompanying the money? (d) How many persons accompanied him?	(a) (b) © (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? © By what conveyance was the money carried?	(a) (b) ©
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? © Was any acknowledgement received from him.	(a) (b) ©

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 loss before? ©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?	(a) (b) © (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 foregoing particulars are true and correct in every respect.

Place:

Date Signature of Insured.

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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

Signature of Claimant

Name:

Date:

Address:

Place:

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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.

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1. (a) Name of Insured:

   (b) Address:

   (c) Policy Number:

   (e) Sum Insured under the Section:

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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

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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:

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W.C CLAIM FORM

(The issue of this form does not constitute admission of liability)

Claim No. :

1		EMPLOYER/INSURED
(A)	Name	(A)
(B)	Address	(B)
(C)	Business/Ocupation	(C)
2		INSURANCES EFFECTED

Company	Policy No.	Full Description of Interest covered

(If Insurance is effected with companies other than IFFCO-Tokio , copies of all policies to be attached)

3 INJURED PERSON

(a) Name

(b) Local/Permanent address

(c) Age/Sex

(d) Sate nature of work for which the injured person was employed

(e) Was the injured person engaged in the occupation when the accident occurred? If not, state exactly nature of work done at that time.

(f) Is the injured person in your direct employ? If so, state the date of appointment. If not, give name and address of contractor under whom employed and nature of work entrusted to contractor (Copy of the last voucher obtained from the injured person for the wages paid to be attached)

(g) Under what Item of the policy is the injured workman covered?

4 ACCIDENT

(a) Premises at which accident occurred

(b) Exact occupation of the premises and general nature of work done

(c) Time and date of occurrence of accident

(d) Time when reported and by whom

(e) Time and date when the injured person actually ceased work

(f) Describe how the accident occurred

(g) are you satisfied that the accident occurred in the course of and arising out of employement?

(h) Was the injured person under the influence of drink of drugs at

the time of accident?

(l) Was the Injured person guilty of misconduct or disobedience to orders or rules?

(j) State whether the accident ocurred as a result of negligence on the part of any employee.

(k) Has the accident been reported to police or inspector of Labour? (A copy of the report to be attached)

5 LOSS

(a) Describe the nature of injury and part of body affected

(b) Describe initial treatment offered. When and whether admitted in hospital? Name of Hosp., whether as inpatient or outdoor patient.

(c) How long is the injured person expacted to be in hospital

(d) what is the medical opinion on nature and extent of disablement? (A copy of the preliminary Medical Report to be attached)

(e) How long is the disablement expected to last? (A copy of the fitness certificate of attendant doctor to be obtained after returning to work)

(f) Have you any other insurance covering the workman against Personal Accident, E.S.I. Scheme? If so, give details

I /We hereby declare that the foregoing particulars are true and correct in every respect.

Place :

Date :

STATEMENT OF WAGES

(A) If the injured person has been in the Employer's service during a continious period of more than one month immediately preceding the accident, then the wages that have been paid, or fallen due for payment , to him in each month of such period not exceeding twelve months in all) must be entered in th statement.

(B) If the injured person has been in the Employer's service for less than one month, then there must be entered in the stateme the wages paid to another workman employed on the same kind of work by the employer during the twelve months immediately preceding the accident.

(C) If worker is a daily paid employee, give (a) daily rate of wages and (b) number of days on an average that he/she would work in a month (a) (b)

TABLE OF WAGES

1	2	3	4	5
Month & Year	Basic Pay & D.A.	Overtime, Bonus and Dearness Allowance	Concession in value of food-stuffs	Value of free quarte (10% basic wages)
		- -		
		- -		
		- -		
		- -		
		- -		
		- -		
		- -		
		- -		

Total earnings in the period

From

To
Average monthly wages

**In Column " Absence" give date of going on leave or beginning of period of absence and also date of subequent resumption of work.

The above statement of earnings etc.. Is, to the best of my knowledge and belief accirate

Place :

Signature of Employer

Date :

[Add below any additional information available regarding the accident]

IFFCO-TOKIO GENERAL INSURANCE COMPANY LIMITED

REGISTERED OFFICE: 34, NEHRU PLACE, NEW DELHI – 110019

Claim No.: _____

Date of Issue: _____