

CONSEQUENTIAL LOSS (FIRE) OF PROFIT CLAIM FORM

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

Note: The claim form is to be duly filled and signed by the insured. All facts and statements must be factual not influenced or biased in any favour. **Policy Number** INSURED DETAILS Name of the Proposer (in full): Address of the Proposer: State Pin code Mobile Landline **Fmail** *Please note that claim cheque (if any) will be dispatched to the address mentioned above. This address will be updated in above mentioned policy. **Bank Details: Bank Name** Branch Type of A/c A/c no Pan No **IFSC Code** MICR code **DETAILS OF ACCIDENT** Date and time of Accident/ Occurrence: D M M Y Y H H M M AM/PM D Please state the nature of business: 5. What is the situation of premises affected and equipments involved in the damage? 7. Please state the cause of loss Please indicate the corresponding Fire Policy Number and identify the affected machine under the policy. 8. Did the damage result in total stoppage of the business? \square YES \square NO If NO, please state the extent (in percentage) up to which the output was affected: _ 10. Please detail the steps taken to minimize the interruption period. \square by utilizing other available plant \square by overtime work in the unaffected portion of the work by installation of hired or loaned machine. 11. How many hours daily did the affected departments work and how many days of a week? 12. How many working hours do you estimate were lost? 13. What is the total output of the Department/ plant/ works affected during the 12 months immediately prior to the loss/ breakdown. 14. Has there been any saving in standing charges? ☐ YES ☐ NO If YES, please give details: Claim Form_ Consequential Loss (Fire) of Profit UIN: : IRDAN132P0003V01200708 Page 1 of 2



15.	Has there been any increase in a cost of working to maintain protection? ☐ YES ☐ NO
	If YES, please give details:
16.	What was the loss in output due to damage to the equipment? On what basis this figure has been calculated
DE	TAIL OF OTHER INSURANCES
17.	Give details of other Insurance, if any, covering the present loss
DE	TAILS OF PREVIOUS LOSSES
18.	Give details of previous Claims, if any, on the project
DE	CLARATIONS
info	We hereby declare that the details given above are true and correct to the best of my belief and knowledge. In event above rmation or any part thereof is found incorrect, I/We agree that all rights under the policy will be fortified. I/We also agree to vide additional information to the company, if required.
Date	e: Proposer Signature:
	Ruture Generali India Insurance Company Limited

Corporate & Registered Office:- 801 and 802, 8th Floor, Tower C, Embassy 247 Park, L.B.S. Marg, Vikhroli (W), Mumbai – 400083 Call Us at:- 1800-220-233 / 1860-500-3333 / 022-67837800 Email:- fgcare@futuregenerali.in Website:- www.futuregenerali.in IRDA Regn. No. 132, CIN - U66030MH2006PLC165287



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