

FG PACK & PROTECT CLAIMS FORM

ISSUE OF THIS CLAIMS 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 additional particulars may be sent later

The claim form is to be duly filled and signed by the insured. All facts and statements must be factual, and not influenced or biased in any favour.

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Policy Number _____

Period of Insurance _____ to _____

Claim Number _____

Geographical Limits

A. DETAILS OF INSURED/CLAIMANT

Name of the Insured		
Address		
	City	
	State	
	Pin code	
Contact details	Phone Number	
	Mobile Number	
	Email ID	
Brief Description of Business / /Occupation/Profession		
Sum Insured under the Policy (Rs.)		

B. DETAILS OF LOSS/ACCIDENT

Date of Loss ____/____/____ Time of Loss ____ A.M. / P.M.

Loss Location Address _____

City _____ State _____

Pin Code _____

Please provide the details of the person who discovered the loss.

Name _____

Relationship with Insured _____

Phone Number _____ Mobile Number _____

Email ID _____

 Describe Cause of Loss/Damage

 Estimated Loss (Rs.)

WITNESS DETAILS:

 Were there any witnesses to the loss / accident? _____ (Yes) (No),
 If 'Yes',

Name of the Person's		
Address		
	City	
	State	
	Pin code	
Contact details	Phone Number	
	Mobile Number	
	Email ID	

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	
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Information Report No./Authority Reference No. and Date		
Contact Person/s		
Address		
	City	
	State	
	Pin code	
Contact details	Phone Number	
	Mobile Number	
	Email ID	

C. DETAILS OF OTHER INSURANCE

Is the loss/damage covered under any other Insurance _____ (Yes) (No),

If 'Yes', specify details and attach a copy of the policy

Name of Insurer		
Address		
	City	
	State	
	Pin code	
Contact details	Phone Number	
	Mobile Number	
	Email ID	
Policy No.		
Period of Insurance	From: _____	To: _____
Sum Insured (Rs.)		

D. DETAILS OF OTHER INFORMATION

Do you wish to provide any other information? _____ (Yes) (No), If 'Yes', specify

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 I/We agree that if I/We have made, or in any further declaration the Company may require in respect of the said loss/damage, any false or fraudulent statement, or any suppression or concealment, my/our claim shall be absolutely forfeited, and the Policy shall be void, and all rights to recover there under in respect of past or future loss/damage shall be forfeited.

Place _____

Signature _____

Date _____

Name of Insured/Claimant _____

*****END*****