

C. INFORMATION TO POLICE AUTHORITY

1. Has the loss been reported to Police Authority? Yes No

If 'No', reason for not reporting

First Information Report No.

Medico Legal Case (MLC) No.

Report Date

Address of Police Station

Plot No/Door No.

Building Name

Road

Area

City

District

State

Pincode

Contact Details

Phone No.

Mobile

E-mail Id

2. Was the person moved to hospital immediately after the accident? Yes No

If 'Yes',

3. Name of Hospital

Address of Hospital

Plot No/Door No.

Building Name

Road

Area

City

District

State

Pincode

Contact Details

Phone No.

Mobile

E-mail Id

4. Date of Admission

Date of Discharge

D. DETAILS OF OTHER INSURANCE

1. Is the Accident/Incidence covered under any other Insurance? Yes No

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

Name of Insurer

Policy No.

Policy Issuance Office Location

Sum Insured (Rs.)

Period of insurance

From

To

E. PAYEE DETAILS [Payable to Nominee (*All fields are mandatory)]

Bank Name

Bank Branch

Bank Account No.

IFSC Code

MICR No.

PAN No.

Note: It is agreed that the Policyholder/Claimant will intimate in writing to SBI General about any change in bank account details. Please attach a cancelled cheque pertaining to the same account. In case premium is issued from the same bank account through cheque, the cancelled cheque is not required.

F. FOR WHICH BENEFIT DO YOU CLAIM? [PLEASE TICK (✓) THE APPROPRIATE BOX]

Benefit	Amount claimed	Benefit	Amount claimed
<input type="checkbox"/> Accidental Death		<input type="checkbox"/> Temporary Total Disability (TTD)	
<input type="checkbox"/> Permanent Total Disability (PTD)		<input type="checkbox"/> Adaptation Allowance	
<input type="checkbox"/> Permanent Partial Disability (PPD)		<input type="checkbox"/> Education Benefit	

G. ANY OTHER INFORMATION YOU MAY WISH TO PROVIDE

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 make in any further declaration, the Company may require in respect of the said accident, any false or fraudulent statement, or any suppression or concealment, my/our claim shall be absolutely forfeited.

I/We hereby extend my/our consent to the Company for sharing my/our personal data with State Bank Group entities for specific purpose of availing services offered by State Bank Group (please strike this clause in case you do not wish to disclose the personal data).

Place

Signature of Insured/Claimant _____

Date

Name of Insured/Claimant _____

ANNEXURE I: TO BE COMPLETED BY NOMINEE IN THE EVENT OF INSURED'S DEATH

1. Name of Nominee

2. Relationship with Insured Date of Birth Sex M F

3. Address Plot No/Door No. Building Name
 Road Area
 City District
 State Pincode

4. Contact Details Phone No. Mobile
 E-mail ID

If nominee is minor, kindly provide the Legal Guardian details

5. Name of Guardian

6. Relationship with Insured Date of Birth

7. Address Plot No/Door No. Building Name
 Road Area
 City District
 State Pincode

8. Contact Details Phone No. Mobile
 E-mail Id

I/We hereby declare and warrant the truth of the foregoing particulars in every respect. I/We agree that if I/We have made or shall make false or untrue statement, suppression or concealment, my/our right to compensation shall be forfeited.

I/We also hereby declare that I am/we are accepting the amount in full discharge of your obligations under the policy to the Insured Person and /or his/her legal heirs. I/we will hold you indemnified in the event of any claim under this policy being made against you by any other person or persons.

Place

Signature _____

Date

Name of Nominee _____

ANNEXURE II: MEDICAL CERTIFICATE - TO BE FILLED BY TREATING DOCTOR

1. Name & Address of the Insured

2. Gender Male Female Date of Birth / Age /

3. Nature of the Accident/Incident and details of injuries sustained _____

4. Cause of Accident/Incident _____

5. Are the injuries:

a) Solely due to Accident/Incident Yes No

b) Traceable to any disease Yes No

If 'Yes', give details _____

c) Traceable to any previous injury Yes No

If 'Yes', give details _____

6. Was insured under influence of drugs / alcohol / intoxicants at the time of accident? Yes No

7. Is the injured person suffering from any disease or injury which may have contributed to the accident or likely to aggravate his/her condition or delay improvement? Yes No

If 'Yes', give details _____

Details of Disablement _____

Nature of Disablement

a) Permanent Total Disablement Yes No

b) Permanent Partial Disablement Yes No

c) Temporary Total Disablement Yes No

Details of Disablement _____

Details of treatment given _____

8. According to you, how long should the injured person be confined to bed/house as the direct and sole consequence of the injury sustained? From To

9. During this period will the injured person be able to attend to his/her normal duties? Yes No

If 'Yes', from

If 'No', please state probable date of his / her being able to attend to his normal duties

I certify that I have examined the above named Insured, the above statements are correct.

Name of treating Doctor

Qualifications Registration No.

Address

Contact Details Phone No.

E-mail Id

Signature of the Doctor _____ Date

Stamp of the Doctor _____ Stamp of the Hospital _____

H. ENCLOSURES CHECKLIST

Please attach following documents and tick appropriate box. (Please attach documents as per benefit claimed and tick appropriate box)

1. Accidental Death:

- Claim Form duly filled & signed
- Claim Intimation
- Police Copy
- Copy of FIR (First Information Report) / Spot Panchnama / Inquest Panchnama
- Death Certificate
- Death Summary
- Post Mortem Report
- Original Legal Heir Certificate (in case nomination has not been filed by deceased)

3. Education Benefit:

- All documents of List - 1 or List - 2, plus
- Study Certificate from the school of the dependent child mentioning the parent's name

4. Adaptation Allowance:

- All documents of List - 2, plus
- Original Bills and payment receipt of Adaptation done
- Prescription of the doctor mentioning the indication for Adaption

2. Permanent Total Disablement / Permanent Partial Disablement / Temporary Total Disablement:

- Claim Form duly filled & signed
- Claim Intimation
- Police Copy
- Copy of FIR (First Information Report) / Spot Panchnama / Inquest Panchnama
- Photograph of the injured with reflecting disablement
- Disability Certificate from appropriate Government Authority
- Medical Certificate from treating Doctor
- Leave Certificate from the Employer
- Investigation Reports
- Treatment Papers

Note: The Company reserves the right to seek additional documents (including KYC documents) and information as and when necessary for processing of the claim.