



# Universal Sampo General Insurance Co. Ltd.

(A joint venture between Allahabad Bank, Sampo Japan Insurance Inc., Indian Overseas Bank, Karnataka Bank and Dabur Investments.)

Regd. Office: 201-208, Crystal Plaza, Opp. Infiniti Mall, Link Road, Andheri (West), Mumbai - 400 058.

## CONSEQUENTIAL LOSS CLAIM FORM

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

If any detail or information is not readily available please do not delay dispatch of this form and such particulars may be sent later.

Policy No. \_\_\_\_\_

Claim No. \_\_\_\_\_

### A. INSURED

Name	_____		
Address line 1	_____	City	_____ Pin Code _____
Address line 2	_____	State	_____
Phone No.	_____	Mobile No.	_____ Email _____
Business/Occupation	_____	Period of Insurance From	__/__/____ To __/__/____
Limits of Indemnity under the Policy	_____		

### B. DETAILS OF LOSS

Date of Loss	__/__/____	Time	__:__ AM / PM
<b>LOSS LOCATION</b>			
Address line 1	_____		
Address line 2	_____		
City	_____	State	_____ Pin Code _____
Phone No.	_____	Mobile No.	_____ Email _____
Describe cause of Loss/Damage	_____		
Estimated Loss (Rs.)	_____		

#### WITNESS DETAILS

#### INFORMATION TO AUTHORITY

Is any witness available for accident / loss? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes", specify	Have any authority been informed about Accident / Loss? If "Yes", specify <input type="checkbox"/> Yes <input type="checkbox"/> No
Name of the witness _____	Name of the Authority _____
Address line 1 _____	Contact Person _____
Address line 2 _____	Authority reference no. _____
City _____	Address line 1 _____
State _____	Address line 2 _____
Pin Code _____	City _____ State _____
Phone No. _____	Pin Code _____
Mobile No. _____	Phone No. _____ Mobile No. _____
Email _____	Email _____

### C. DETAILS OF OTHER INSURANCE

Is the Loss/damage covered under any other Insurance? If "Yes", specify details and attach copy of policy <input type="checkbox"/> Yes <input type="checkbox"/> No
Name of the Insurer _____
Address line 1 _____
Address line 2 _____
City _____ State _____ Pin Code _____
Phone No. _____ Mobile No. _____
Policy No. _____ Email _____
Period of Insurance From __/__/____ To __/__/____ Amount of Insurance _____

**D. DETAILS OF OTHER INTEREST**

Is the insured sole owner of the property? If "No", specify details  Yes  No

Nature of Insured interest \_\_\_\_\_

Person/s who has interest on property \_\_\_\_\_

His nature of interest \_\_\_\_\_

Address line 1 \_\_\_\_\_ Address line 2 \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Pin Code \_\_\_\_\_

Phone No. \_\_\_\_\_ Mobile No. \_\_\_\_\_ Email \_\_\_\_\_

**E. DETAILS OF CONSEQUENTIAL LOSS**

Whether any alteration has been made in the nature of business / occupation of premises after inception of Policy  Yes  No  
 If "Yes", please give details \_\_\_\_\_

Were the premises occupied at the time of loss  Yes  No  
 If no, un-occupied since \_\_/\_\_/\_\_\_\_ for reasons \_\_\_\_\_

Details of Material Damage under Fire & Special Perils Policy / MBD Policy

Name of the Insurer \_\_\_\_\_

Address line 1 \_\_\_\_\_ Address line 2 \_\_\_\_\_

City \_\_\_\_\_ Pin Code \_\_\_\_\_ State \_\_\_\_\_ Phone no. \_\_\_\_\_

Policy No. \_\_\_\_\_ Period of Insurance \_\_/\_\_/\_\_\_\_ to \_\_/\_\_/\_\_\_\_

Sum Insured : (a) Building \_\_\_\_\_ (b) P&M \_\_\_\_\_ (c) FFF \_\_\_\_\_ (d) Stocks \_\_\_\_\_

At the time of loss, the premises were occupied as : Manufacturing facility  Warehouse  Dwelling

Amount of Material Damage loss :(Rs.)

(a) Building \_\_\_\_\_ (b) P&M \_\_\_\_\_ (c) FFF \_\_\_\_\_ (d) Stocks \_\_\_\_\_

Period for which the business was interrupted due to fire / MBD \_\_/\_\_/\_\_\_\_ to \_\_/\_\_/\_\_\_\_

What was the annual turn-over for the last financial year? Rs. \_\_\_\_\_

What is the estimated reduction in turn-over due to interruption? Rs. \_\_\_\_\_

What is the estimated loss of Gross Profit due to interruption? Rs. \_\_\_\_\_

Standing Charges / Expenses incurred for Loss Minimization, if any, Rs. \_\_\_\_\_

Was there any person / organization, in your opinion, responsible for the loss?  Yes  No  
 If "Yes", please provide details along with contact numbers and address, if available (this information will be used only for investigation of this claim and source will not be divulged to the suspected party)

\_\_\_\_\_

What steps have been taken to prevent recurrence of similar incidence? \_\_\_\_\_

\_\_\_\_\_

**F. DETAILS OF PREVIOUS LOSSES**

Claims lodged during the preceding 3 years

Claim Year	Claim Description	Amount Rs.

**G. DETAILS OF OTHER INFORMATION**

Do you wish to provide any other information?  Yes  No

If "Yes", specify \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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, and all rights to recover thereunder in respect of past or future loss/accidents shall be forfeited.

**Place:**

**Signature:**

**Date:**

**Name of Insured:**