

ALL RISK POLICY CLAIMS FORM

Issuance of this claim form is not to be taken as an admission of liability.

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.

If any detail or information is not readily available, please do not delay the dispatch of this form. Such particulars may be sent by the Insured later separately.

Policy Number														
Claim No														
Policy Period	From	To												
Name Of Insured/Claimant														
Address	City: State: Pin code:													
Contact Details	Phone No. Mobile No. Email Id:													
Coverage Category (as specified in the Schedule)														
Property/Item Details														
Identification details														
Property Lost/Damaged (Pls attach list of the parts / components along with amount)														
Type of Loss/Damage / Section under which claim is lodged														
	In case, the claim has triggered in any of the optional covers listed below. Please provide the details <table border="1" style="width: 100%; margin-top: 10px;"> <thead> <tr> <th style="width: 60%;">Selected Optional Covers</th> <th></th> </tr> </thead> <tbody> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> </tbody> </table>		Selected Optional Covers											
Selected Optional Covers														
Date Of occurrence of Insured Event														

Time Of occurrence of Insured Event	Am/Pm
Insured Event Location Address	City: State: Pin code:
Briefly narrate how the Insured Event Occurred	
Claimed Amount	
Date of Purchase of Property/Item	
Contact Details Of Person/s At Loss Location Name Relationship With Insured Contact Details	
Witness Details: Were There Any Witnesses To The Insured Event? Yes/No,	If Yes, Name Of Person/S Address City State Pin code Contact Details 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 <input type="checkbox"/> Police <input type="checkbox"/> Municipality <input type="checkbox"/> Other <input type="checkbox"/> Name Of Authority: Information Report No./Authority Reference No. And Date: Contact Person/S Address City State

	Pin code Contact No. Email Id						
Details Of Other Insurance Is the loss/damage covered under any other insurance Yes/No	If Yes, Specify Details & Attach A Copy Of The Policy Name Of Insurer Address City State Pin code Contact No. Email Id Policy No, Policy Period To Sum Insured						
Details Of Other Interest Is The Insured The Sole Owner Of The Property? Yes/No	If No, Specify Nature Of Interest Person/S Who Has/Have Interest On Property Address City State Pin code Contact No Email Id						
Details Of Items Affected							
Sr. No .	Descripti on of Property	Invoic e no.	Identificati on details	Make/ Mode l	Sum Insured in (₹)	Year of manufactur e	Cost of Repair/Replac ement



Does the insured item hold special value as a part of a pair/set?

Yes / No

Has the affected equipment undergone any repairs previously?

Yes / No

If "Yes", the nature of such repairs

Date of repair	Nature of repair	Parts affected	Cost of Repair (Rs)

Details of Previous Losses

Losses during the 3 preceding years, including under any other insurance:

Date of loss	Claim description and Cause of loss	Value of loss (Rs.)	Insurer

Details of Other Information

Do you wish to provide any other information? Yes No, If "Yes", please specify below or add separate sheet.

Declaration

I/We agree to provide any additional information to the Company, if required, in relation to the loss or damage. I/We, the above mentioned, do hereby, to the best of my/our knowledge and belief, warrant the truth of the foregoing statement(s) and document(s) 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 of any fact deemed material, my/our claim shall be absolutely forfeited, and the Policy shall be void without any refund of premium, and all rights to recover there under in respect of past or future loss/damage shall be forfeited.

Date:

Place:

Signature of Insured: Name of Insured/Claimant:

Generali Central Insurance Company Limited (Formerly known as Future Generali India Insurance Company Limited) | Registered Office: Unit No. 801 & 802, 8th Floor, Tower C, Embassy 247 Park, LBS Marg, Vikhroli (West), Mumbai – 400083 | **IRDAI Regn. No.:** 132 | **CIN:** U66030MH2006PLC165287 | **Website:** <https://generalicentralinsurance.com> | **Email ID:** gccicare@generalicentral.com | **Toll-free Phone:** 1800 220 233 / 1860 500 3333/ 022 6783 7800