

Shriram General Insurance Company Limited

Farmer's Package Policy: Claim Form (All Sections)
THE ISSUE OF THIS FORM DOES NOT CONSTITUTE ADMISSION OF LIABILITY

Claim No.
A. INSURED DETAILS

1	Name	:	
2	Address	:	
3	Occupation	:	
4.	Policy No.	:	
5.	Period of Insurance	:	From To
6	Telephone Number/ Mobile no.	:	

B. DETAILS OF THE PROPERTY LOST/DESTROYED/DAMAGED:

1	Location details where the loss occurred.	
2	Details of the items lost /damaged	
3	Date & Time of Loss.	
4	Give brief details of how exactly the loss occurred.	
5	Amount of Loss	
6	Initiatives taken for recovery of salvage	

C. DETAILS OF THE LIVESTOCK DEATH LOSS:

1	Animal type and no. of animal	
2	Cause and date of death	
3	Tag no.	
4	Death certificate no.	
5	Total Claim amount	

D. DETAILS OF THE PERSONAL LOSS
1. PERSONAL DETAIL;

1.	Name of claimant	
2.	Address	
3	Occupation/ age	

2. DETAILS OF ACCIDENT:

1.	Time and Date	
2.	Location of Accident/ incident	
3.	Cause (Description)	
4.	Total Disablement if any(specify the type)	

i) WITNESSES IF ANY:

Name	Address	Phone No

ii) POLICE REPORT:

Has a complaint been lodged with the Police station? (Yes/No) If Yes, by whom, when & at which Police station? (Attach a copy of the police report).
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iii) TREATMENT DETAILS:

	Name	Address	Phone No	Registration No
(a).Doctor				
(b) Hospital(s)				

E. DETAILS OF OTHER INSURANCE

1.	Give details of other Insurance's, if any, covering the present loss.	
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F. DETAILS OF PREVIOUS LOSSES

2.	Give details of Previous losses, if any, on the affected property.	
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I/We hereby declare that the foregoing particulars are true and correct in every respect and that the articles or properties described herein belong to me/us, with no other person having any interest therein, whether as Owner, Mortgage, Trustee or otherwise.

I further authorize the hospital, doctor, laboratory, organization, establishment or any other body or person dealt with in the course of this claim to give any information or document sought for by the Insurance Company.

Date

Place

Signature of the Insured/Claimant

ATTENDING PHYSICIAN'S STATEMENT

1.	Name of Injured Person	
2.	Age	
3.	Address	
4.	Nature of the Accident and Details of Injuries Sustained	
5.	Does the Cause of Accident as stated by the Claimant tally with the Injuries noticed by you?	
6.	Are the injuries solely due to the accident or traceable to any previous injuries/ disease/ infirmities?	
7.	Was the injured person suffering from any disease or injury which may have contributed to the accident or likely to aggravate his condition?	
8.	Was the Claimant hospitalized? If so for what period?	
9.	Was he under the influence of intoxicants or drugs at the time of accident	
10.	Are you his usual medical Attendant? If you have treated him for any previous illness or injury, please give details	
11.	Have other Doctors been in Attendance or Consultation? If yes, Please give details	
12.	Has this accident been reported to the Police Authorities? If yes, Case No: Police Station :	
13.	Details about disablement due to accident	

Date

Place

Name and Signature of Physician