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Shriram General insurance Co. Ltd.

IN PARTNERSHIP WITH THE **Sanlam GROUP**
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Shri Loan Protect Insurance (Individual)- Claim Form

The issue of this form is not to be taken as an admission of liability. Please ensure that all columns of the claim forms are filled in by the insured and no column remains unanswered. Attach Separate Sheet if the space is not sufficient.

1. INSURED DETAILS

1.	Policy Number:	Claim Number:	
2.	Period of Insurance:		
3.	Name:		
4.	Address:		
5.	Contact Number:	Landline:	Mobile:
6.	E-mail:		
7.	Loan Account Number:		
8.	Principal Outstanding Amount:	EMI:	

Section (A) Personal Accident

- Date of loss/injury: Date: _____ Time of Accident: _____ AM/PM
- Place of loss/injury: _____
- Particulars of loss/injury: _____
- Reason for injury: _____
- Nature of injury received
(if to eye or limbs, please state left or right?) _____
- Nature of disablement _____
- Present state of disability _____

8. Names & Addresses of _____
 Treating physicians & _____
 Hospitals _____

City: _____ Pin Code: _____

State: _____ Country: _____

Phone: _____

Section (B)

i. Loss of employment

1. Name of the employer _____
 2. Address _____
 _____ HR Contact details _____
 3. Designation _____ Department _____
 4. Date of Joining the Organization _____ Date of Separation _____
 5. Reason for separation _____

ii. Loss of Earnings

1. Business/ Occupation Details _____
 2. Address _____

 3. Monthly Income _____
 4. Last 3 years Financial Statements _____
 5. Books of Accounts _____

Section (C) Child Care Allowance

Details of child 1

1. Name _____
 2. Date of Birth _____ Birth Mark _____
 Gender Male ☐ Female ☐

Details of child 2

1. Name _____
 2. Date of Birth _____ Birth Mark _____
 Gender Male ☐ Female ☐

Section (D) Critical Illness

Select one of the below against which claim is being made.

Cancer ☐ First heart attack ☐ Open chest CABG ☐ Open heart replacement ☐

Kidney failure ☐ Stroke ☐ Major Organ ☐ Paralysis ☐

Primary (Idiopathic) Pulmonary Hypertension ☐ Multiple sclerosis ☐

Name of Insured _____ Date of first diagnosis/ occurrence/ procedure _____

Place _____

Nature of Sickness _____

Circumstances of loss/ sickness _____

Name & Address of treating hospital / doctor _____

City _____ State _____ Pin Code _____

Date of Birth (if applicable) _____ Place of Death _____

2. DETAILS OF PREVIOUS LOSS:

Sr.	Date of Loss	Amount of Loss	Name of Insurance Company
1.			
2.			
3.			

3. DETAILS OF OTHER INSURANCES AND CO-INSURANCES, IF ANY:

Sr.	Name of the Company	Policy Number	Sum Insured
1.			
2.			
3.			

I/ We, undersigned confirmed that the above given details are true & correct to the best of my knowledge.

Date:

Place:

Signature of the Insured