

HDFC ERGO General Insurance Company Limited

Contractors All Risk - CLAIM FORM



The issue of this form is not to be taken as an admission of liability.

Policy No _____

Notification of Loss or Damage for Contractor's All Risk Insurance

Claim No: _____

Title of contract insured _____

Name(s) and address(es) of insured (s) _____

Location and address of contract site _____

Name of supervising engineer _____

Nearest railway station(airport) _____

Advisable approach route to contract site from railway station (airport) or otherwise

1. Which items were damaged?

a) Contract works b) Construction plant and equipment c) Construction machinery

2. When did the loss or damage occur? (state date and exact time) _____

3. How did the damage occur and what was it probable cause? (attach sketches, photos etc.) _____

4. How far had construction of the damaged item progressed at the time of the occurrence of damage? _____

5. Give name and address of witness to the occurrence _____

6. How will the damaged items be repaired _____

7. Will any alterations or improvements be made to design, construction or material when repairs are carried out? _____

8. What are the estimated costs for the repair of damage to

a) Contract works b) Construction plant and equipment c) Construction machinery

9. Is third party liability involved? _____

10. Are existing buildings or surrounding property damaged? _____

11. Remarks _____

The undersigned Insured declares to have answered the above questions conscientiously and truthfully.

Dated _____ this _____ day of _____ 200_____

I/We hereby understand, declare, consent and authorise the Company that personal health details, medical history and financial information, as provided to the Company may be utilised for processing the claim made under the Policy. I/We hereby also understand, declare and consent that the Company shall have right to retain and disseminate the same to any service provider for providing services related to insurance.

Signature of the Claimant

HDFC ERGO General Insurance Company Limited



Consent for Mode of Claim Payment

Name of Insured

Policy Number

Claim Number

Beneficiary Name

Mode of Payment Cheque Fund Transfer

(Please tick for mode of payment)

(All Fields are Mandatory in case of Fund Transfer)

Insured's Name as per Bank Account

Bank Account Number

Branch Name

IFSC Code

Email address

Attachments
In Support of Bank Details
(Please tick the type of proof submitted)

Cancelled Cheque

Bank Passbook Copy

Declaration: I Mr./ Mrs/ Ms. _____
undersigned, legal beneficiary of the above claim, declare that all details mentioned in this form are true and I agree to the mode of payment against the particular claim number mentioned above.

Signature of Beneficiary
Stamp Required in case of Company

Date: