BHARTI AXA GENERAL INSURANCE COMPANY LIMITED, RMZ Infinity, B - Tower, 2nd Floor, No. 3, Old Madras Road, Bangalore - 560016. Tel: 080-40260200. Toll-Free Helpline: 1800-103-2292 E-mail: claims@bharti-axagi.co.in www.bharti-axagi.co.in



## SHOPKEEPER'S INSURANCE CLAIM FORM

THE ISSUE OF THIS FORM IS NOT TO BE TAKEN AS AN ADMISSIBILITY OF LIABILITY.
Please fill this form in <b>Block Letters</b> and <b>Tick the Boxes</b> where appropriate and do not leave any column unanswered If any detail or information is not readily available, please do not delay despatch of this report and such particulars may be sent later.
Policy Number:
Claim Number:
Period of Insurance: DIDIMIMIYIYIYI to DIDIMIMIYIYIYIY
A. DETAILS OF INSURED/s
Name:
Address:
Pin code: Pin code:
Telephone No:
E-mail Address:
Financial Interest:
Address of Financer:
Pin code:
If Insured is not the sole owner, for the nature of his/their interest in the property and the details of other Interests, a separate sheet may be enclosed.
B. LOSS DETAILS
The West of the Control of the Contr
Time and Date of loss: (Hrs.)
The address of the accident site/location
Who noticed the loss & when
Please attach a statement of the person.
Details of the circumstances leading to loss and cause:  Please attach separate sheet, if necessary.
Nature of Loss Fire Burglary Machinery Breakdown
Others, (Please specify)
Please give the address where the affected items can be inspected:
The approximate amount of loss

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	C. LOSS INTIMATION	
Whether loss has been intimated to	Fire Brigade Yes No	Police Authorities Yes No
If yes, please attach the copies of the reports.		
D. PRE	VIOUS LOSS HISTORY, IF A	NY
		2000°
E. DETAILS OF OTHE	ER INSURANCES ON AFFE	TED PROPERTY
E IN CASE OF ACT OF GO	D PERILS, PLEASE ATTACH	PELEVANT PEPOPTS
THE CASE OF ACT OF GO	D I ERIES, I EEASE ATTACT	RELEVANT REPORTS
G. IN YOUR OPINION, IS A	ANY THIRD PARTY RESPON	ISIBLE FOR THE LOSS
If yes name and address of such person		
n yes name and dadress of sach person.		
I/We hereby declare that the above questions I		
correctness and completeness of the statement.	I/We shall provide any additional info	ormation, if needed.
Date:		
Place:		Signature of Insured
		signature of insured



## BHARTI AXA GENERAL INSURANCE COMPANY LIMITED