

BUSINESS PACKAGE (COMMERCIAL) CLAIM FORM

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

Period of Insurance: From DOTAMAYYYY to DOTAMAYYYY 1. Datable of Policy Holder Insured / Claimant's Name: Addresse:	Policy No.:		Claim	No.:	
Insured / Claimant's Name: Address: City.	Period of Insurance: Fr	om $\frac{DD/MM/YYYY}{}$ to	DD/MM/YYYY		
Address: City:	1. Details of Policy Ho	lder			
City:Pin Code:	Insured / Claimant's Na	me:			
City:Pin Code:	Address:				
Mobile No.: Landline No.: Eminil ID.: Details of Mortgagee/Financiers (s): 2. Loss Details Date of Loss: DO MM/YYYY Time of Loss. HH/MM AM/PM Description of Loss: DO MM/YYYY Time of Loss. HH/MM AM/PM Description of Loss: DO MM/YYYY Time of Loss. HH/MM AM/PM Description of Loss: Do MM/YYYY Time of Loss. HH/MM AM/PM Description of Loss: Do MM/YYYY Time of Loss (Rs.) 1					
Enable Discription of Loss: D7 MM / YYYY	City:	Pin Code:	State:		
Details of Mortgagee/Financiers (s): 2. Loss: DT MM / YYYY Time of Loss: HH7MM AMPM Description of Loss: Items affected (Attach separate sheet, if required):			Landline No.: _		
Date of Loss: DD / MM / YYYY Time of Loss: HI / MM AM/PM Description of Loss: Items affected (Attach separate sheet, if required): S. No. Damage/Lost Items Identification No. (if any) Estimated Loss (Rc.) 1 2 3 3 4 5 5 Additional information in event of legal liability / Injury to Insured or Insured's Employee *In event of Hospitalization, attach necessary medical records 4. Police & Fire Brigade Details Police report ladged: Yes No if Yes, Report No:	·				
Items affected (Attach separate sheet, if required):	2. Loss Details				
Items affected (Attach separate sheet, if required):	Date of Loss: DD / MN	Time of Loss: HH/	MM AM/PM		
Items affected (Attach separate sheet, if required): S. No. Damage/Lost Items					
S. No. Damage/Lost Items Identification No. (If any) Estimated Loss (Rs.) 1 2	Description of Loss:				
S. No. Damage/Lost Items Identification No. (If any) Estimated Loss (Rs.) 1 2					
*In event of Hospitalization, attach necessary medical records 4. Police & Fire Brigade Details Police report lodged: Yes No If Yes, Report No: District: Fire Brigade Intimation: Yes No If Yes, Report Details: 5. Other Insurance Details Is the loss covered under any other insurance policy: Yes No If Yes, Report Details: S. No. Name & Address of Insurance Company Policy No. From To Sum Insured (Rs) 1 2 Declaration Declaration Declaration S. No. Name & Address of Insurance Company Policy No. From To Sum Insured (Rs) The Company of the provide additional information to the Company of Regulated Liver Insurance Company Policy No. From To Sum Insured (Rs) Declaration Declaration S. No. Name & Address of Insurance Company Policy No. From To Sum Insured (Rs) The Company of the provide additional information to the Company Regulated Liver Insurance Company Policy No. From To Sum Insured (Rs) Declaration Declaration S. No. No. Name & Company Regulated Liver Insurance Company Policy No. From To Sum Insured (Rs) The Company of the Company of Regulated Liver Insurance Company Policy No. From To Sum Insured (Rs) The Company of the Company of Regulated Liver Insurance Ins	Items affected (Attach	separate sheet, if required):			
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A. Police & Fire Brigade Details Police report lodged:					
A. Police & Fire Brigade Details Police report lodged:					
Police Population:	* In event of Hospitaliz	ation, attach necessary medical red	cords		
Police Station: Fire Brigade Intimation: Yes No If Yes, Report Details:	4. Police & Fire Brigad	e Details			
Police Station: Fire Brigade Intimation: Yes No If Yes, Report Details:		П., П.,, -			-
Fire Brigade Intimation: Yes No If Yes, Report Details: S. Other Insurance Details	Police report lodged:	☐ Yes ☐ No If Yes, Report N	lo.:		Date: DD/MM/YYYY
S. No. Name & Address of Insurance Company Policy No. From To Sum Insured (Rs)	Police Station:			District:	
Is the loss covered under any other insurance policy: Yes No If Yes, then give the details below S. No. Name & Address of Insurance Company Policy No. From To Sum Insured (Rs) Declaration We agree to provide additional information to the Company, if required. I/We the above named, do hereby, to the best of my/our knowledge and belief, warrant the truth of the foregoing statement in every respect, and if I/We have made, or in any further declaration the Company may require in respect of the said accident, shall make any false or fraudulent statement, or any suppression or conceilment, the policy shall be void Dotto Privacy Notice I/We hereby provide consent to the Company from the Company in formation relating to MeUs in challenged Sensitive Personal Information ("hereingher crumulatively referred to as 'INFORMATION"), that is either available with the Company or disclosed by MeUs while obtaining the policy of Insurance from the company or otherwise. I/We further understand that the Company may use the INFORMATION by respuritory the Insurance policy obtained by MeUs and too some may shape the INFORMATION with any reinsurer, insurance association, medicalcularborities, other Insurance in the company or disclosed by MeUs and too some men shape the INFORMATION with any reinsurer, insurance association, medicalcularborities, other Insurance in the company or the war of the same as one to enable the own of the company or the same in writing and also understand that, in the event of such withdrawal by MeUs, the Company reserves the right to not provide MeUs, the Company reserves the right to not provide MeUs, the Company reserves the right to not provide MeUs, the Company reserves the right to not provide MeUs, the Company reserves the right to not provide MeUs, the Company reserves the right to not provide MeUs, the Company of the same in writing and also understand that, in the event of such withdrawal by MeUs, the Company reserves the right to not provide MeUs the Services for which it has sought the INFORMATIO	Fire Brigade Intimation:	Yes No If Yes, Repo	rt Details:		
S. No. Name & Address of Insurance Company Policy No. From To Sum Insured (Rs) 1 2 Declaration	5. Other Insurance De	tails			
S. No. Name & Address of Insurance Company Policy No. From To Sum Insured (Rs) 1 2 Declaration	Is the loss covered under	er any other insurance policy:	Yes No	If Vac than aive the date	vila halaw
Declaration I/We agree to provide additional information to the Company, if required. I/We the above named, do hereby, to the best of my/our knowledge and belief, warrant the truth of the foregoing statement in every respect, and if I/We have made, or in any further declaration the Company may require in respect of the said accident, shall make any false or fraudulent statement, or any suppression or concealment, the policy shall be void and all rights to recover thereunder in respect of past or future accidents shall be forfieted. I understand that the Company reserves the right of verification of facts and advantage to a state of the said accidents shall be forfieted. I understand that the Company reserves the right of verification of facts and advantage to expense the company of the company of the said excidents shall be wild the company of the said excidents shall be forfieted. I understand that the Company of the said excidents of the company of the said excidents shall be wild the company of the said excidents of the company of the said excidents of the company of the said excidents shall be foreigned by the company of the said excidents shall be foreigned by the company of the said excidents shall be wild the company of the said excidents of the said excidents of the said excidents shall be wild the company of the said excidents of th	.5 4.15 1555 5575754 41.145	and the same and t		ii res, their give the dett	alls below
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Declaration	 				
I/We agree to provide additional information to the Company, if required. I/We the above named, do hereby, to the best of my/our knowledge and belief, warrant the truth of the foregoing statement in every respect, and if I/We have made, or in any further declaration the Company may require in respect of the said accident, shall make any false or fraudulent statement, or any suppression or concealment, the policy shall be void and all rights to recover thereunder in respect of past or future accidents shall be forfeited. I understand that the Company reserves the right of verification of facts and documents relating to the policy and claim. Data Privacy Notice I/We hereby provide consent to the Company for collection/fetaining any information relating to Me/Us including Sensitive Personal Information (Thereinatine crumulatively referred to as "INFORMATION", that is either available with the Company or disclosed by Me/Us while obtaining the policy of Insurance from the company or otherwise. I/We further understand that the Company may use the INFORMATION', that is either available with the Company or disclosed by Me/Us while obtaining the policy of Insurance association, medical authorities, other Insurers, statutory authorities, court, governmental body, regulator etc., or with services provider(s) enanged by the Company for servicing the Insurance policy. underwriting the risk, settlement of claim etc. without obtaining our specific consent for such harding and we hereby provide our consent to Company for same. I/We understand that whenever I/We would like to update/correct the INFORMATION accordingly. Further in the event I/We would like to withdraw My/Our consent provided herein, I/We would intimate the Company of the same so as to enable the Company to amend/correct the INFORMATION. Date: DD / M M / Y Y Y Y	2				
Date: DD/MM/YYYY Signature of Insured					
Date: DD/MM/YYYY Signature of Insured	I/We agree to provide additional and if I/We have made, or in any t and all rights to recover thereund	information to the Company, if required. I/We the al further declaration the Company may require in res ler in respect of past or future accidents shall be for	bove named, do hereby, to the be pect of the said accident, shall mo feited. I understand that the Com	st of my/our knowledge and belief, war ke any false or fraudulent statement, o pany reserves the right of verification o	rant the truth of the foregoing statement in every respect, or any suppression or concealment, the policy shall be void of facts and documents relating to the policy and claim.
Date: DD/MM/YYYY Signature of Insured	Data Privacy Notice I/We here "INFORMATION"), that is either of INFORMATION for servicing the Ir	by provide consent to the Company for collecting available with the Company or disclosed by Me/Us and for same ma	/retaining any information relati while obtaining the policy of Insu y share the INFORMATION with a	ng to Me/Us including Sensitive Perso irance from the company or otherwise ny reinsurer, insurance association, med	onal Information ("hereinafter cumulatively referred to as . I/We further understand that the Company may use the dical authorities, other Insurers, statutory authorities, court,
Date: DD/MM/YYYY Signature of Insured	sharing and we hereby provide or Company to amend/correct the I	, or with services provider(s) engaged by the Comp ur consent to Company for same. I/We understand t NFORMATION accordingly. Further in the event I/ uch withdrawal by Me/Lls, the Company research	that whenever I/We would like to i We would like to withdraw My/C e right to not provide Me/Lis the Se	picy, underwriting the risk, settlement of update/correct the INFORMATION, we Jur consent provided herein, I/We wou rvices for which it has sought the INFOR	or claim etc. without obtaining our specific consent for such will intimate the Company for the same, so as to enable the Ild intimate the Company of the same in writing and also RMATION
Signature of Insured	and or stand triat, in the event of st	and a war by interest, the company reserves th	agric to not provide Me/os tile Se		
	Date: DD/MM/YY	YY			
	Place:			_	

Navi General Insurance Limited

Registered Office: Navi General Insurance Limited