

Claim Form No: \_\_\_\_\_

**ERRORS & OMISSIONS LIABILITY POLICY - CLAIM FORM**

ISSUE OF THIS CLAIM FORM IS NOT TO BE TAKEN AS AN ADMISSION OF LIABILITY

|                     |                                       |
|---------------------|---------------------------------------|
| Policy Number       | Claim Number                          |
| Period of Insurance | From DD / MM / YYYY To DD / MM / YYYY |

**A. DETAILS OF INSURED/CLAIMANT: (To be filled in BLOCK LETTERS)**

|                                      |                                                                                                                                |                |  |
|--------------------------------------|--------------------------------------------------------------------------------------------------------------------------------|----------------|--|
| Name of the Insured                  | <input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms.    F I R S T    M I D D L E    L A S T |                |  |
| Address                              |                                                                                                                                |                |  |
| City                                 | State                                                                                                                          |                |  |
| Pin Code                             | Phone Number                                                                                                                   |                |  |
| Mobile Number                        |                                                                                                                                |                |  |
| Email ID                             |                                                                                                                                |                |  |
| Trade or Business                    | Date of Last Premium Paid                                                                                                      | DD / MM / YYYY |  |
| Limits of Indemnity under the policy |                                                                                                                                |                |  |

**B. DETAILS OF LOSS:**

|                                                                                                                                        |                |                 |                |
|----------------------------------------------------------------------------------------------------------------------------------------|----------------|-----------------|----------------|
| 1. Date of alleged error omission                                                                                                      | DD / MM / YYYY | Date claim made | DD / MM / YYYY |
| 2. Details Of Claimant                                                                                                                 |                |                 |                |
| Full name of the claimant or potential claimant (i.e. the party making the claim or potential claim upon the Insured)                  |                |                 |                |
| Address of the claimant                                                                                                                |                |                 |                |
| 3. Details of Claim or Circumstance                                                                                                    |                |                 |                |
| What is the precise nature of the claim (i.e. the claimant's allegations) or the fact or circumstance that might give rise to a claim? |                |                 |                |
| Have proceedings been commenced? If so, please attach a copy of the court documents.                                                   |                |                 |                |
| On what date did you first become aware of the claim or of the fact or circumstance?                                                   |                |                 |                |
| On what date was the claim or the intimation of a claim first made to you?                                                             |                |                 |                |


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Was the first intimation of a claim oral or in writing? If in writing please attach a copy.  
 If oral, please give a "first person" account of the conversation, (i.e. "I said", "He said").

What amount, if any, is claimed? If known, what does that amount comprise?

#### 4. Details of Insured's Response

What are your comments in response to the claim or the fact or circumstance that might give rise to a claim?

What are your comments on the quantum of the claim and what is your estimate of your Potential monetary liability, if any, to the claimant?

Have you appointed a solicitor or other lawyer to act for you? If so, what is the lawyers / solicitor name, Firm, address and charge out rates?

5. Provide copies of any correspondence you have received from the claimant

6. Provide copies of any correspondence received from a lawyer along with any court documentation

7. Advise where you were served with the litigation/court documents

8. Advise when you were served with the litigation/court documents

9. Name of the claimant's Lawyer and address

10. What actions you have taken to prevent a reoccurrence or similar claim?

| WITNESS DETAILS                                                                                                   |  | INFORMATION TO STATUTORY AUTHORITY                                                                            |  |
|-------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------|--|
| Were there any witnesses to the loss/accident? <input type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes |  | Has the loss been reported to an Authority <input type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes |  |
| Name of Person's                                                                                                  |  | Name of Authority                                                                                             |  |
| Address                                                                                                           |  | Authority Reference No.                                                                                       |  |
|                                                                                                                   |  | Contact Person's                                                                                              |  |
|                                                                                                                   |  | Address                                                                                                       |  |
| City                                                                                                              |  |                                                                                                               |  |
| State                                                                                                             |  | City                                                                                                          |  |

|               |  |               |  |
|---------------|--|---------------|--|
| Pin Code      |  | State         |  |
| Phone Number  |  | Pin Code      |  |
| Mobile Number |  | Phone Number  |  |
| Email ID      |  | Mobile Number |  |
|               |  | Email ID      |  |

### C. DETAILS OF OTHER INTEREST

Is the Insured the Sole Owner of the property? ☐ Yes ☐ No If 'No', specify

Nature of Interest

Person/s who has/have interest on property

Address

City

State

Pincode

Phone Number

Mobile Number

Email ID

### D. DETAILS OF PREVIOUS LOSSES

Losses during the 3 preceding years

| Date of Loss | Claim Description and Cause of Loss | Value of Loss (Rs.) | Insurer |
|--------------|-------------------------------------|---------------------|---------|
|              |                                     |                     |         |
|              |                                     |                     |         |
|              |                                     |                     |         |

### E. DETAILS OF OTHER INFORMATION

Do you wish to provide any other information? ☐ Yes ☐ No If Yes Please Specify

Give the details of Statute/ Law under which in your opinion liability may arise



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I/We, the above named, do hereby, to the best of my/our knowledge and belief, warrant the truth of the foregoing statements in every respect; and I/We agree that if I/We have made, or make in any further declaration, the Company may require in respect of the said accident, any false or fraudulent statement, or any suppression or concealment, my/our claim shall be absolutely forfeited, and the Policy shall be null and void, and all rights to recover there under in respect of past or future loss/accident shall be forfeited

Date: \_\_\_\_\_

Place: \_\_\_\_\_

\_\_\_\_\_  
 Insured's Signature with Company Seal

#### BANK DETAILS

Would you like to opt for  
 NEFT payment?

☐ Yes ☐ No

If YES, please enclose a cancelled cheque leaf along with the claim form.

Bank Name

Branch Name

A/C Holder Name as in Bank  
 Record

City

State

Account No

IFSC Code

(this is a 11 digit code printed on your cheque leaf)

#### DECLARATION BY INSURED

I/We hereby declare that the statements made by me/us in this claim form are true to the best of my/our knowledge and belief.  
 I/We hereby state that the above mentioned address shall be taken as address on record for the purpose of GST.

Date: \_\_\_\_\_

Place: \_\_\_\_\_

\_\_\_\_\_  
 Signature of Insured

#### REGISTERED & CORPORATE OFFICE ADDRESS

**IRDAI Registration No. 103, IndusInd General Insurance Company Limited (Formerly known as Reliance General Insurance). Registered & Corporate Office:** 6th Floor, Oberoi Commerz, International Business Park, Oberoi Garden City, Off. Western Express Highway, Goregaon (E), Mumbai - 400063.

For assistance call **(022) 4890 3009 (Paid)**