

HDFC ERGO General Insurance Company Limited



FIDELITY GUARANTEE - CLAIM FORM

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

Claim No _____ Policy No _____ D.O/UNIT _____

1. a) Name of employer in full _____
 b) Business _____
 c) Address _____
2. a) Name of the defaulting employee in full station _____
 b) His present address _____
3. Amount of loss sustained _____
4. Date of defalcation _____
5. Date of discovery of the defalcation _____
6. How exactly was the defalcation committed? _____
(if the space is not sufficient, please give full and detailed particulars on a separate signed sheet. Also please attach a certified statement containing all entries in your books of accounts relative to the declaration in their order of dates).
7. Please reply fully to the following questions regarding the duties of the employee at the time of defalcation:
 - a) In what capacity was he engaged and where? _____
 - b) In what way did moneys reach his hands? _____
 - c) What was the largest sum which he had in his hands at any one time and for how long? _____
 - d) Was he allowed to pay out any amounts on your behalf? _____
 - e) Who authorized these payments? _____
 - f) Was he required to give printed receipts from a book with counterfoils? If so, how often were the counterfoils examined and checked, and by whom? _____
 - g) Where moneys paid into the bank by the defaulting employee? If so, how often were the bank books examined and checked, and whom? _____
 - h) What balance, if any was allowed to be kept in his hand? _____
 - i) How often were his cash accounts balanced and how was their accuracy checked? _____
 Please explain fully _____
 - j) How often were accounts sent direct to customers independently of the employee? _____
 - k) Did the employee have charge of stock? If so, how often was it checked? _____
8. How often were the account books at the place of the defaulting employees employment audited and by whom? _____
9. Have you any moneys, estate, or effect of the employee in your possession? If so, give particulars with amounts _____
10. Do you hold any other security from the employee? If so, state its nature an amount. _____
11. Is the defaulter a member of a joint family, or does he hold any property furniture or other effects? If so, give details _____
12. Has the employee any near relatives? If so, give their names and address if known _____
13. Have you taken any action against the employee? If so, state of what nature _____
14. Has the loss been reported to the police? If so, state at which police station and what action, if any, has been taken by them _____

I/We the above named, do hereby, to the best of my/our knowledge and belief, warrant the truth or the foregoing statements in every respect and I/We agree that I/We have made, or in any further declaration the Company may require in respect of the said occurrence, shall make any false or fraudulent statement or any suppression or concealment my/ our claim shall be absolutely forfeited, and the policy shall henceforth be null and void.

I/We hereby understand, declare, consent and authorise the Company that medical details 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 Witness

Name: _____

Address: _____

Date:

D	D	M	M	Y	Y	Y	Y
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Place:

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Insured's Signature

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 Cancelled Cheque Bank Passbook Copy
In Support of Bank Details
(Please tick the type of proof submitted)

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: