

## CLAIM FORM PROFESSIONAL INDEMNITY POLICY FOR CHARTERED ACCOUNTANTS/ FINANCIAL ACCOUNTANTS/MANAGEMENT CONSULTANTS/LAWYERS/ ADVOCATES/SOLICITORS/ COUNSELS

(The issue of this form is not to be taken as an Admission of Liability)

The completion and return of this form to the Company should not be delayed if any of the particulars required cannot be immediately given, they may be forwarded to the Company afterwards as soon as possible.

### DETAILS OF INSURED

|  |                                  |  |
|--|----------------------------------|--|
|  | Name                             |  |
|  | Policy No.                       |  |
|  | Occupation/Profession of Insured |  |
|  | Address                          |  |
|  | Contact No                       |  |
|  | Email id                         |  |

Are you or any of the proposed applicants/beneficial owner a PEP\* or Family member/Close relatives/Associates of PEP\*?

☐ Yes ☐ No

If yes, please give details (Nature of relationship and position held by PEP): \_\_\_\_\_

"Politically Exposed Persons" (PEPs) are individuals who have been entrusted with prominent public functions by a foreign country, including the heads of States / Government, senior politicians, senior government / judicial / military officers, senior executives of state-owned corporations and important political party officials;".

### DETAILS OF CLAIM

|  |                                                                                                |  |
|--|------------------------------------------------------------------------------------------------|--|
|  | Name of the Claimant                                                                           |  |
|  | Address                                                                                        |  |
|  | Contact No.                                                                                    |  |
|  | Date of claim                                                                                  |  |
|  | Amount of claim                                                                                |  |
|  | Capacity in which the claimant is making the claim<br>i.e. as client, third party, any other)  |  |
|  | Allegation in the claim<br>( Please attach a copy of the claim notice )                        |  |
|  | <b>In case you anticipate a claim, please specify</b>                                          |  |
|  | The reason why you anticipate such a claim,<br>Nature of error or omission if any on your part |  |
|  | From whom and when you anticipate such a claim                                                 |  |

### ICICI Lombard General Insurance Company Limited

IRDA Reg. No. 115

Mailing Address:

601 / 602, 6th Floor, Interface Building No. 16,  
New Link Road, Malad (West),  
Mumbai - 400 064.

CIN : L67200MH2000PLC129408

Registered Office Address:

ICICI Lombard House, 414, Veer Savarkar  
Marg, Near Siddhivinayak Temple,  
Prabhadevi, Mumbai 400 025.

CLAIM FORM PROFESSIONAL INDEMNITY POLICY FOR CHARTERED ACCOUNTANTS/ FINANCIAL ACCOUNTANTS/ MANAGEMENT CONSULTANTS/LAWYERS/ ADVOCATES/ SOLICITORS/ COUNSELS

Toll free no : 1800 2666

Alternate no : 8655222666 (Chargeable)

E-mail : customersupport@icicilombard.com

Website : www.icicilombard.com

UIN: IRDAN115RP0009V01200203 (Retail)

**OTHER DETAILS**

|  |                                                                                          |  |
|--|------------------------------------------------------------------------------------------|--|
|  | Mention the type of professional service provided to the Claimant / prospective claimant |  |
|  | When was the service provided to Claimant / prospective claimant                         |  |
|  | When and how did you first come to know of the error/omission                            |  |
|  | Address of the location/construction site where the error/negligence has occurred        |  |
|  | Brief description of the incident which can lead to claim                                |  |
|  | Give particulars of any other insurance, if any in respect of the same risk.             |  |

**I/We hereby agree, affirm and declare that:**

- (a) The statements/information given/stated by me/us in this incident reporting form are true, correct and complete.
- (b) No material information which is relevant to the processing of the claim or which in any manner has a bearing on the claim has been withheld or not disclosed.
- (c) If I/we have given/made any false or fraudulent statement/information, or suppressed or concealed or in any manner failed to disclose material information, the policy shall be void and that I/We shall not be entitled to all/any rights to recover thereunder in respect of any or all claims, past, present or future.
- (d) The receipt of this incident reporting form/other supporting/related documents does not constitute or be deemed to constitute an agreement by the Company of the claim and the Company reserves the right to process or reject or require further/additional information in respect of the claim.

Date:   /   /    Place:                

Signature of Insured:

**ICICI Lombard General Insurance Company Limited**

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## CLAIMS REPORTING FORM For CHARTERED ACCOUNTANTS/ FINANCIAL ACCOUNTANTS/MANAGEMENT CONSULTANTS/LAWYERS/ ADVOCATES/ SOLICITORS/COUNSELS

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

This will be in continuation of the Incident Reporting Form dated

\_ \_ \_ \_ \_

This form is only for the purpose of intimating the Company about the claims made. Insured shall not enter into compromise/settlement without the written permission of the Company. The completion and return of this form to the Company should not be delayed if any of the particulars required cannot be immediately given. They may be forwarded to the Company afterwards as soon as possible.

### DETAILS OF INSURED

|  |            |  |
|--|------------|--|
|  | Name       |  |
|  | Address    |  |
|  | Contact No |  |
|  | Email id   |  |
|  | Policy No. |  |

### DETAILS OF ALLEGED CLAIM

|  |                                                            |  |
|--|------------------------------------------------------------|--|
|  | Alleged Date & Time of Error/Omission/negligence           |  |
|  | Name of the person who has been alleged for Error/Omission |  |
|  | Designation                                                |  |
|  | Qualification                                              |  |
|  | Brief description of the event                             |  |

### DETAILS OF CLAIMANT

|  |                                                                                                                                                                                              |  |
|--|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
|  | Give name/es, address/es occupation/s of Claimant (Attach separate sheet, if space not sufficient )                                                                                          |  |
|  | Details of Injury/death/damage/loss to the claimant (Attach separate sheet, if space not sufficient )                                                                                        |  |
|  | Number of victims                                                                                                                                                                            |  |
|  | Mention the capacity under which the claim is being made by the claimant (Attach the written complaint/notice given by the claimant)                                                         |  |
|  | Has the accident caused damage to property? If so, give name/s and address/es of the owner/s of the property and full description of the property and state the nature and extent of damage. |  |
|  | Mention the amount of compensation claimed                                                                                                                                                   |  |

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**COMPROMISE DETAILS**

|  |                                                                                                                           |  |
|--|---------------------------------------------------------------------------------------------------------------------------|--|
|  | Do you agree that you are liable for the incident.<br>Give reasons                                                        |  |
|  | Reasons for compromise / settlement Please provide comprehensive detail of all reasons, game-plans/strategy for the same. |  |
|  | What is the present status of compromise/ settlement negotiations?                                                        |  |
|  | What is the quantum of liability, you are proposing to agree to?                                                          |  |

**COURT PROCEDURE**

|  |                                                                                                                |  |
|--|----------------------------------------------------------------------------------------------------------------|--|
|  | Has any case been filed in any court of law/tribunal against you, in relation to the incident ?                |  |
|  | Have any notices / summons of the court been received by you? If yes, please provide copies of the same.       |  |
|  | Details of the main Parties of the legal Proceedings                                                           |  |
|  | Has the court passed any interim or final order? If yes, please provide copies of the same                     |  |
|  | Also provide copies of all the documents that have been submitted to the Court either by you or the Claimants. |  |

**DETAILS OF LEGAL ADVICE**

|  |                                                                                                                                                                            |  |
|--|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
|  | The Insured's proposed response to the alleged claim/complaint?                                                                                                            |  |
|  | Does the insured propose to/has already availed of, any legal advice.                                                                                                      |  |
|  | If Yes, details of the lawyer/law firm together with their opinion                                                                                                         |  |
|  | If No, the proposed steps by the Insured to evaluate the legal liability risk in the context of its response/proposed response and the facts having bearing on the matter. |  |
|  | Estimated Legal/Defence Cost/fees which will be incurred                                                                                                                   |  |

**MISCELLANEOUS**

|  |                                                                       |  |
|--|-----------------------------------------------------------------------|--|
|  | Any other evidence in support of claim.                               |  |
|  | Give particulars of any other insurance, in respect of the same risk. |  |

**I/We hereby agree, affirm and declare that:**

- (a) The statements/information given/stated by me/us in this incident reporting form are true, correct and complete.
- (b) No material information which is relevant to the processing of the claim or which in any manner has a bearing on the claim has been withheld or not disclosed.
- (c) If I/we have given/made any false or fraudulent statement/information, or suppressed or concealed or in any manner failed to disclose material information, the policy shall be void and that I/We shall not be entitled to all/any rights to recover thereunder in respect of any or all claims, past, present or future.
- (d) The receipt of this incident reporting form/other supporting/related documents does not constitute or be deemed to constitute an agreement by the Company of the claim and the Company reserves the right to process or reject or require further/additional information in respect of the claim.

Date:   /   /    Place:               

Signature of Insured:

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## CLAIM SETTLEMENT FORM FOR CHARTERED ACCOUNTANTS/ FINANCIAL ACCOUNTANTS/MANAGEMENT CONSULTANTS/LAWYERS/ ADVOCATES/ SOLICITORS/COUNSELS

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1. What is the quantum of the settlement that has been arrived at between you and the Claimants?  
Please provide proof of the following (agreement, understanding, court order, court award etc)
2. If decided by a court, what is the quantum of liability imposed on you?  
Please provide copy of the court award.
3. What are the total defence costs that have been incurred by you, till date, if any?

### Claim Clause/ Settlement of Claim:

- 1) Claim Intimation: Connect with us via: Toll-free no.: 1800 2666,

Email ID: customersupport@icicilombard.com, on our

website: <https://coclaims.icicilombard.com/claimstracker/CommercialClaims/ccplandingpage.aspx>

Register the claim and submit claim related documents along with claim form. You will receive a claim reference number as your reference point for future correspondence.

- 2) File an FIR: In case of third-party property damage/bodily injury, fire etc. if applicable as per policy terms and conditions.
- 3) Surveyor Appointment: Your Claims Manager (CSM) will contact you and appoint a licensed surveyor basis claim eligibility within 24 hours of reporting the claim
- 4) Documents: submit documents to the assigned CSM/Surveyor.

List of documents which are necessary and relevant to the claim are as below:

1. Claim bill / Claim Form duly filled up
2. Photographs / Video of damaged property/item under claim
3. Document/s in support of admissibility of the claim, for instance, all proceedings filed before the courts, communications exchanged with the insured, invoices, payment proofs, internal/external investigation report of the insured, Insureds counsel opinion on merits and demerits of the case, insured counsel engagement letter etc.
4. FIR / Final Police investigation report wherever applicable
5. For items which are to be repaired or reinstated, repair/ replacement quotation, invoice and payment proofs for each and every item as claimed.
6. For items which are under claim & not to be repaired or reinstated, documents substantiating the quantum & value of the items under claim
7. Offer for retention of salvage, if any
8. KYC / NEFT Details as per AML guidelines
9. Invoice copy / Goods Receipt Note / Monetary Claim on carrier / Damage Certificate
10. Any other document which may be specified by the surveyor post completion of initial survey
- 5) Assessment Approval: Repair/Replacement details submitted in support of the claim will be assessed and approved by CSM/surveyor
- 6) Salvage: The amount that is assessed which the damaged asset will fetch in the open market (wherever applicable).
- 7) Turnaround Time (TAT): Assessment sheet / Survey report will be furnished within 15 days of receipt of claim form and documents. Claim will be decided within 7 days of receipt of the assessment sheet / survey report, as applicable.

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## DECLARATION

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- (c) If I/we have given/made any false or fraudulent statement/information, or suppressed or concealed or in any manner failed to disclose material information, the policy shall be void and that I/We shall not be entitled to all/any rights to recover thereunder in respect of any or all claims, past, present or future.
- (d) The receipt of this incident reporting form/other supporting/related documents does not constitute or be deemed to constitute an agreement by the Company of the claim and the Company reserves the right to process or reject or require further/additional information in respect of the claim.
- (e) I/We hereby give my/our consent to the Company to verify and obtain my/our identity/address proof as well as the identity /address proof of the Insured / Beneficial Owner through Central KYC Registry or UIDAI or through any other modes for the purpose of undertaking KYC.

Date:    /    /

Place:

Signature of Insured:

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