FUTURE GENERALI
TOTAL INSURANCE SOLUTIONS

TOLL FREE PHONE: 1800 103 8889
TOLL FREE FAX: 1800 103 9998
E MAIL: fgh@futuregenerali.in

# ACCIDENT SURAKSHA CLAIM FORM

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

**Note: The claim form is to be duly filled and signed by the insured. All facts and statements must be factual not influenced or biased in any favour.**

**Policy Number** ☐☐☐☐☐☐☐☐

## INSURED DETAILS

1. **Name of the Insured (in full):**

2. **Address of the Proposer:**

| | |
|---|---|
| | |
| | |
| **State** | **Pin code** |
| **Mobile** | **Landline** |
| **Email** | |

## DETAILS OF ACCIDENT

3. **Date and time of Accident:** D D M M Y Y   H H M M **AM/ PM**

4. **Please state the place of Accident**

______________________________________________

5. **Please provide brief details of accident/ incidence**

______________________________________________

## DETAILS OF INJURIES SUSTAINED

6. **Please specify the section under which the claim is lodged**

| **Primary Covers** | **Additional Covers** | |
|---|---|---|
| ☐Accidental Death | ☐Child Education Support | ☐Loan Protector |
| ☐Permanent Total Disablement | ☐Life Support Benefit | ☐Repatriation Benefit and Funeral Expenses |
| ☐Permanent Partial Disablement | ☐Accidental Medical expenses | ☐Adaptation Allowance |
| ☐Temporary Total Disablement | ☐Accidental Hospitalisation | ☐Family Transportation Allowance |
| | ☐Hospital Cash Allowance | |

7. **In Case of Death: Please provide following details:**
   a. **Name of Nominee:** ______________________________
   b. **Address of Nominee:** ______________________________
   ______________________________________________

8. **Specify injured parts of the body:**______________________________

9. **Please specify nature of Disability:**______________________________

10. **In case of Permanent Partial Disablement: Please mention disability percentage**

    **Percentage:** ______________ **(%)** ______________________________**(In words)**

11. **In case of Confinement/ Away from work: Please mention the period of confinement (This should be the actual days when fully confined to bed on Medical Advise)**

    **Total Confinement: From** ________________**To**________________

    **Partial Confinement: From** ________________**To**________________

12. **Have the Police been informed about the accident?** ☐ **YES** ☐ **NO**

    **If YES, please give following details**

    **MLC No:** ______________________________**FIR No:** ______________________________

    **Name & Address of the Police station:** ______________________________

13. **Was the injured person under the influence of alcohol/ drugs at the time of accident?** ☐ **YES** ☐ **NO**

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**14. Please provide details of medical expense (if covered):**

| Date | Receipt No. | Particulars | Amount |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

***Please attach separate sheet for additional bills / receipt details***

**15. Please provide following details of Witnesses**

**Name:** ______________________________

**Address:** ______________________________

______________________________

**Contact No:** ______________________________

**Name:** ______________________________

**Address:** ______________________________

______________________________

**Contact No:** ______________________________

**16. Please provide following details**

**CASUALTY DOCTOR**

**Name:** ______________________________

**Address:** ______________________________

______________________________

**Contact No:** ______________________________

**FAMILY DOCTOR**

**Name:** ______________________________

**Address:** ______________________________

______________________________

**Contact No:** ______________________________

**HOSPITAL DETAILS**

**Name:** ______________________________

**Address:** ______________________________

______________________________

**Contact No:** ______________________________

## DETAIL OF OTHER INSURANCES

**17. Are you insured under any other Policy? ☐ YES ☐ NO. If YES, Please give following details**

**Name of company:** ______________________________

**Policy no:** ______________________________

**Period of insurance:** ______________________________

**Policy issuing office:** ______________________________

## DETAILS OF PREVIOUS CLAIMS

**18. Have you made any Claims in Past? ☐ YES ☐ NO. If YES, Please give details including**

**Nature of Accident:** ______________________________

**Insurance details:** ______________________________

**Claim amount:** ______________________________

## DECLARATIONS

**I/ We hereby declare that the details given above are true and correct to the best of my belief and knowledge. In event above information or any part thereof is found incorrect, I/We agree that all rights under the policy will be fortified. I/We also agree to provide additional information to the company, if required.**

**Date:** ______________________________ **Insured/ Nominee Signature:** ______________________________

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## ATTENDING PHYSICIAN'S STATEMENT

*(To be filed by attending Physician only)*

1. **Name of insured Person:** ______________________________
2. **Age of insured Person:** ______________________________
3. **Nature of the Accident and Details of Injuries Sustained:** ______________________________

   ______________________________
4. **Does the cause of Accident as stated by the Claimant tally as per your opinion?** ☐ **YES** ☐ **NO**
5. **Are the injuries solely due to the accident?** ☐ **YES** ☐ **NO**

   **If No pls. provide the details**______________________________
6. **Was the injured person suffering from any disease or injury which may have contributed to the accidentor likely to aggravate his condition?** ☐ **YES** ☐ **NO**
7. **Was the claimant hospitalized?** ☐ **YES** ☐ **NO**

   **If YES, then please provide period of hospitalization: From:** ______________**To**________________
8. **What treatment/ procedure/ operations performed?**______________________________

   ______________________________
9. **Give all dates of treatment:**

   **Home: From:** ______________**To**________________

   **Clinic/ Hospital: From:** ______________**To**________________
10. **Was he/she under the influence of intoxicants or drugs at the time of accident?** ☐ **YES** ☐ **NO**
11. **Are you his family doctor?** ☐ **YES** ☐ **NO**

    **If you have treated him for any previous illness or injury, please give details**

    ______________________________
12. **Have other Doctors been in Attendance or Consultation?** ☐ **YES** ☐ **NO**

    **If yes, Please give details:** ______________________________

    ______________________________
13. **Has this accident been reported to the Police Authorities?** ☐ **YES** ☐ **NO**

    **If yes, Case No:** ___________ **Police Station.**______________________________
14. **Is this claimant totallydisabled from each and every occupation?** ☐ **YES** ☐ **NO**
15. **How long was or will the claimant be totally disabled from current occupation?From:** ______________**To**________________
16. **How long was or will the claimant be partially disabled from current occupation?From:** ______________**To**________________
17. **Estimated date of return to Work:** ______________________________
18. **What is the Prognosis?**

______________________________

______________________________

**Doctor's Signature:** ______________________________

**Doctors Name:** ______________________________

**Address and Tel. no. :** ______________________________

**Date:** ______________________________

**Regn No:** ______________________________

______________________________

Future Generali India Insurance Company Limited
Registered office address : Indiabulls Finance Centre, Tower 3, 6th Floor, SenapatiBapat Marg, Elphinstone (W), Mumbai - 400 013
Corporate Identity No (CIN): U66030MH2006PLC165287 Telephone No 022 4097 6666 and Fax No 22 4097 6900
Email: fgcare@futuregenerali.inwebsite address www.futuregenerali.in

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**Separate claim form required for each claim. PLEASE ENCLOSE A PHOTOCOPY OF THE FUTURE GENERALI HEALTH ID CARD.**

## AUTHORIZATION FOR TRANSFER OF CLAIM AMOUNT BY NATIONAL ELECTRONIC FUND TRANSFER

| | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Name as per Bank Account** | | | | | | | | | | | | | | |
| **Bank Name** | | | | | | | | | | | | | | |
| **Branch Name & Address** | | | | | | | | | | | | | | |
| **Branch Phone No.** | | | | | | | | | | | | | | |
| **Branch MICR Code** | | | | | | | | | | | | | | |
| **Branch IFSC Code for NEFT** | | | | | | | | | | | | | | |
| **( Please attach a Photocopy of a cheque or a blank cheque of your bank duly cancelled for ensuring accuracy of the bank name, branch name, account number & name of account holder printed)** | | | | | | | | | | | | | | |
| **Account Type (Please Tick)** | **Savings** | | | | **Current** | | | | **Cash / Credit** | | | | | |
| **Account No. (as appearing in Cheque Book)** | | | | | | | | | | | | | | |
| **HR Authorization & Stamp** | | | | | | **Bank Authorization & Stamp** | | | | | | | | |

**Date from which the mandate should be effective: ______________________**

**I hereby declare that the particulars given above are correct and complete and request you to remit any amount due to me, if any to the aforesaid bank account. I herewith further declare that if any transaction is delayed or not effected at all or is wrongly credited to any other account for reasons of incomplete or incorrect information as provided above, I shall not hold Future Generali India Insurance Company Ltd ("Company") or any of its directors, employees or agents responsible for the same. I also declare that the remittance of any dues to the aforesaid bank account shall be considered as full and valid discharge of its obligations by the company. I also undertake to advise any change in the particulars of my bank account to facilitate updation of records for the purpose of credit of any amount due, through NEFT.**

**Name of Employee / Proposer: ___________________________________ Signature of Employee / Proposer: __________________________________________**

**Policy No. _________________________________ Claimant Name: ________________________________________________ Date: ___________________**

**FEEDBACK AND SUGGESTIONS**

**We thank you for choosing Future Generali as your Insurance provider. We always strive to ensure that our service levels exceed our customer's expectations. In the spirit of this endeavor, we will greatly appreciate your valuable inputs and feedback. Kindly provide your feedback on your experience with Future Generali and any suggestions for improving our services. We value your time and promise to evaluate your suggestions for improvement of our service.**

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