FUTURE GENERALI
TOTAL INSURANCE SOLUTIONS

FUTURE TRAVEL INSURANCE- CLAIM FORM

Please contact our 24 hour Helpline Number **+91 22 67347841** (with call back facility anywhere in the world) **OR**
You may use Country specific numbers as mentioned below in – **''HOW TO REACH US''**. Failure to intimate your claim within 24 hours to our Assistance Company shall invalidate your claim.

Note:-

1. Issuance of the form does not imply acceptance of the liability or a waiver of terms, conditions & exclusions of policy.
2. Please attach all Originals bills, receipts, credit card slips or bank statement to your claim. (Mandatory)

1. Policy Number -	2. Passport No -
3. Policy Start Date -	4. Policy End date -
Please Indicate any other insurance coverage (In India/overseas) -	**Policy Number/s :**
5. Name of the Insured Person (in whose name the policy is issued)	
6. (a)Name of the Claimant Person (in respect of whom the claim is made)	
(b) Relationship to the Insured -	(c) E-mail ID/s :-
(d) Contact Numbers (INDIA) -	(e) Contact Numbers (Overseas) -
(e) Residential Address (INDIA) –	

Trip Details: - Date of Departure: ____/____/_____ Flight No: _____ From _____ To _____
Date of Arrival: _____/_____/_____ Flight No: _____ From _____ To _____

Claim in Respect of following section (*please tick against the applicable claim type*)

A. Medical Care		**B. Travel Inconvenience**		**C. Personal Care**	
Medical Expense	☐	Hijack Distress Allowance	☐	Baggage Loss	☐
Repatriation of Remains	☐	Trip Delay	☐	Baggage Delay	☐
Emergency Medical Evacuation	☐	Trip Cancellation	☐	Compassionate Visit	☐
Daily Allowance in case of Hospitalization	☐	Trip Curtailment	☐	Financial Emergency	☐
Emergency Sickness Dental Relief	☐	Missed Connection	☐		
Balance Period of Policy	☐	Loss of Passport	☐		

D. Personal Accident		**E. Special Care**		**F. Legal Liability**	
Accidental Death.	☐	Golfers Hole in one Celebration.	☐	Personal Liability.	☐
Permanent Total Disability.	☐	Burglary. (Home Contents)	☐		
Accidental Death. (Common Carrier)	☐	Child Escort	☐		
Accidental Death. (Air Travel Only)	☐				

MEDICAL EXPENSE COVERAGE, EMERGENCY DENTAL RELIEF, EMERGENCY MEDICAL EVACUATION

Name of the Hospital: _____

Address of the Hospital: _____

Name of Treating Doctor and Contact details: _____

Details of illness & Treatment: _____

Date of First Symptom ____/____/_____please confirm if the illness was also treated in past (Pre-Existing): Yes ☐ No ☐

Treatment / Hospitalization dates for any illness/disease in past: From ____/____/_____ To ____/_____/_____

Treatment or surgery details of any past illness/ailment: _____

Name of medicines you are routinely taking: _____

PAST HISTORY OF ANY CHRONIC ILLNESS WITH DURATION					
Disease / Ailment					**Duration (Specify Years / Months / Days)**
Hypertension	Yes		No		
Hyperlipidemia	Yes		No		
Cancer	Yes		No		
Osteoarthritis	Yes		No		
Diabetes	Yes		No		
Cardiovascular Diseases	Yes		No		
Asthma / COPD / Bronchitis	Yes		No		
Congenital Internal / External	Yes		No		
Any HIV or STD/Related Ailments	Yes		No		
Alcohol or Drug Abuse	Yes		No		
Any Surgery / Hospitalization	Yes		No		
Any Other Disease / Disability	Yes		No		

Name of Family Physician (INDIA): _____

Email ID and contact details of Family Physician (INDIA): _____

If, Claiming for Medical Evacuation / Compassionate visit then specify reasons for Medical Evacuation) _____

_____

_____

Evacuation Request Place From: - _____

Evacuation Request Place To:-_____

Date of Medical Evacuation required: _____

(PLEASE ATTACH TREATING DOCTOR'S CERTIFICATE FOR THE NECESSITY OF AN ATTENDANT/EVACUATION).

REPATRIATION OF MORTAL REMAINS

Cause of Death/ Medical Transportation: _____ Place of Death: _____
Medical Transportation from _____ to _____ Date of Death/ Medical Transportation: ___/__/_____

ITEM NO	DETAILS OF EXPENSES INCURRED – UNDER MEDICAL EXPENSES	AMOUNT
TOTAL CLAIMED AMOUNT * Kindly specify this total claimed amount.		

FINANCIAL EMERGENCY ASSISTANCE

Date on which fund was lost: ____/____/_____Details of incident of loss of fund i.e. how, when, where _____
_____
Local contact Person (INDIA) who can provide payment security_____ Contact Numbers _____
Name of the Police Station _____ Police Information (FIR) No _____

LOSS OF PASSPORT, LOSS OF BAGGAGE; DELAY IN CHECKED IN BAGGAGE, TRIP DELAY/CURTAILMENT

Date & Time of actual arrival: ____/____/_____ at _____ am/pm.
Date & Time of scheduled arrival ___/____/_____ at _____am/pm
Date & Time of Retrieval of Baggage _____/_____/_____ at _____ am/pm. Total Hours of Delay _____
Details of Incident i.e. how, when, where _____
_____
Date on which baggage/passport was lost:____/_____/_____Place where baggage/passport was lost _____

ITEM NO	DETAILS OF EXPENSES INCURRED – UNDER TRAVEL INCOVENIENCE	AMOUNT
TOTAL CLAIMED AMOUNT * Kindly specify this total claimed amount.		

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

PERSONAL ACCIDENT DEATH / DISABILITY INSURANCE

Claiming for Personal Accident resulting into **DEATH** ☐ / **DISABILITY** ☐ (exact details of Disability) _____
Date of Accident: _____ Place of Accident: _____Claimed Amount: _____
Details & Circumstances of Accident i.e. how, when, where_____

_____

Was the injured person under the influence of alcohol/drugs/medicines at the time of accident: NO☐ / YES ☐ _____
Name of the Police Station informed about accident_____ Police Information (FIR) No _____
Name & Address of Hospital_____
Name & Address of Casualty Doctor _____
Name & address of Insured's Regular physician in India _____
Nominee Name, Address & Contact Details _____

(PLEASE ATTACH ATTENDING PHYSICIAN'S STATEMENT/CIVIL SURGEON CERTIFICATE AS PER STANDARD FORMAT)

AUTHORIZATION FOR TRANSFER OF CLAIM AMOUNT BY NATIONAL ELECTRONIC FUND TRANSFER

Please provide below mentioned details of **INSURED'S INDIAN BANK ACCOUNT** for NEFT payment.	
Bank Name	
Branch Name & Address	Branch Phone No.
Name of Proposer (As per Bank A/c):	Relation with Insured
Account No. (as appearing in Cheque Book)	
Branch IFSC Code for NEFT	Branch MICR Code
Account Type : Savings ☐ Current ☐ Cash / Credit ☐	
Contact numbers in India: ;	; Alternate Email ID:
(Please attach a scanned image of a blank , duly cancelled cheque - of your bank)	

Declaration: - I hereby declare that the particulars given above are correct and complete. If any transaction is delayed or not effected at all for reasons of incomplete or incorrect information, I shall not hold Future Generali India Insurance Company Ltd. responsible. I also undertake to advise any change in the particulars of my account to facilitate updations of records for purpose of credit of claim amount through NEFT. I/ We hereby authorize service provider, Insurance Company & its authorized representative to collect my Medical Records, Treatment Papers, Investigation Reports etc. from Treating Doctor / Family Physician / Hospitals in India or Overseas.

I/ We hereby to the best of my/ our knowledge and belief, warrant the truth of the above details in every respect. I/ We agree that if we have already made or if I/ We make in any of my/ our further statements in respect of the said incident or any false or fraudulent declarations or suppress or conceal any material fact, the policy shall be void and all rights of compensation in respect the presence or future shall be forfeited.

Place: _____ **Signature of the claimant/ Insured**

Date: _____ **Name of the claimant/ Insured**