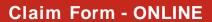
Health Insurance





ALL FIELDS IN THIS FORM ARE MANDATORY (Data will be kept confidential)

	- (E 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1			
Claim Number (If Available):					
POLICY / INSURED DETAILS					
Policy No.:		Health Card No. Of Patient:			
Policy Start Date DD / MM / YYYY Policy End Date		DD/MM/YYYY	Date Of Joining	Policy DD/M	M/YYYY
Corporate Name		(Only for group policies)	Employee ID:	'	
PERSONAL DETAILS OF EMPLOYEE/P	ROPOSER				
1. Name of the Employee/Individual					
2. E-mail address of the Employee/Individu	al				
3. Mobile No.					
4. Permanent Account Number (PAN) CKYC No.(I			Available-For Retail Policies Only):		
CLAIMANT/PATIENT DETAILS	,				
1. Name of the Patient					
2. Relationship with the Employee/Proposer	Parent ☐ Others_				
3. Date of Birth of Claimant: DD / MM / YYYY Age: (years)			: □ Male	☐ Female	□ Other
4. Residential Address:					
CLAIM DETAILS					
Total Claimed Amount:					
Claimed Amount in Words: Rupees					
1. Diagnosis			Enclosure Check List:		111
2. Hospital Name:			Original discharge summary containing all relevant details		
3. Admission Date:		All original bills and their pre-numbered receipts duly signed with a revenue stamp Copies of all reports & prescriptions First prescription/consultation letter from your Doctor CKYC Form, Copy of proposer/employee photo ID			
4. Name of Treating Doctor:					
5. Mobile No. of Treating Doctor:					
6. Name of Family Physician:					
7. Mobile No. of Family Physician:			proof & address proof. [CKYC to be submitted if claimed amount is more than ₹ 1 lac - For Retail Policies Only] • NEFT Form with photocopy of cancelled cheque with printed name of proposer/employee		
8. Details of other existing Health Policies:					
9. Ongoing Medication:					
CONSENT REQUIREMENT FOR ACCI	ESS TO TREATM	ENT PAPERS/INDOC	OR CASE SHEET	CS/MEDICAL R	ECORDS/
I hereby declare that information furnished in this cl suppression of or concealment of any material fact w consent & authorize Future Generali India Insurance attended on the person against whom this claim is n making any supplementary claim except the Pre/Pos	with respect to question as Company, to seek necess hade. I hereby declare that	sked in relation to this clain sary medical information/do	n, my right to claim rein cuments from any hosp	mbursement shall be pital/Medical Practit	e forfeited. I also ioner(s) who has
Name of Patient/Relative:					
Relationship with Patient:					
Signature Not Required					

Future Generali India Insurance Company Limited
Regd. and Corp. Office: 801 and 802, 8th Floor, Tower C, Embassy 247 Park, L.B.S. Marg, Vikhroli (W), Mumbai - 400 083.
Corporate Identity No (CIN): U66030MH2006PLC165287 Telephone No 022 4097 6666 and Fax No 22 4097 6900
Email: fgcare@futuregenerali.in website address www.futuregenerali.in

Date: DD / MM / YYYY