Health Insurance

Claim Form - ONLINE

FUTURE GENERALI
TOTAL INSURANCE SOLUTIONS

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

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 / MM / YYYY
Corporate Name			*(Only for group policies)*	**Employee ID:**	

PERSONAL DETAILS OF EMPLOYEE/PROPOSER

1. Name of the Employee/Individual	
2. E-mail address of the Employee/Individual	
3. Mobile No.	
4. Permanent Account Number (PAN)	CKYC No.(If Available-For Retail Policies Only):

CLAIMANT/PATIENT DETAILS

1. Name of the Patient			
2. Relationship with the Employee/Proposer	☐ Self ☐ Spouse ☐ Child ☐ Parent ☐ Others		
3. Date of Birth of Claimant: DD / MM / YYYY	Age:_____(years)	Gender:	☐ Male ☐ Female ☐ Other
4. Residential Address:			

CLAIM DETAILS

Total Claimed Amount: | | | | | | | | | | |

Claimed Amount in Words: Rupees _____

1. Diagnosis _____	Enclosure Check List:
2. Hospital Name: _____	• Original discharge summary containing all relevant details
3. Admission Date: _____ Discharge Date: _____	• All original bills and their pre-numbered receipts duly signed with a revenue stamp
4. Name of Treating Doctor: _____	• Copies of all reports & prescriptions
5. Mobile No. of Treating Doctor: _____	• First prescription/consultation letter from your Doctor
6. Name of Family Physician: _____	• CKYC Form, Copy of proposer/employee photo ID proof & address proof. [CKYC to be submitted if claimed amount is more than ₹ 1 lac - For Retail Policies Only]
7. Mobile No. of Family Physician: _____	• 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 ACCESS TO TREATMENT PAPERS/INDOOR CASE SHEETS/MEDICAL RECORDS/ INVESTIGATOR VISIT

I hereby declare that information furnished in this claim form is true & correct to the best of my knowledge and belief. If I have made any false or untrue statement, suppression of or concealment of any material fact with respect to question asked in relation to this claim, my right to claim reimbursement shall be forfeited. I also consent & authorize Future Generali India Insurance Company, to seek necessary medical information/documents from any hospital/Medical Practitioner(s) who has attended on the person against whom this claim is made. I hereby declare that I have included all the bills/receipts for the purpose of this claim & that I will not be making any supplementary claim except the Pre/Post -Hospitalization if any.

Name of Patient/Relative: _____ _____

Relationship with Patient: _____

Signature Not Required

Date: DD / MM / YYYY