

**HEALTH INSURANCE CLAIM FORM****ALL FIELDS IN THIS FORM ARE MANDATORY AND THE CLAIM WILL BE NOT BE PROCESSED IF ANY OF THE DETAILS ARE MISSING**

Claim Number (For FGH Use Only)	
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**DETAILS OF PRIMARY INSURED**

Policy No : _____ Health Card No. of Patient _____	
Policy Start Date _____ Policy End Date _____ Date of Joining the Policy _____	
Corporate Name : _____ (Only for Group Policies) Employee ID _____	
1	Name of the Employee / Individual:
2	E-Mail address of the Employee/Individual:
3	Mobile No:
4	Permanent Account Number (PAN):
Address: _____	
City: _____ State: _____ Pincode: _____ Phone No: _____	

**DETAILS OF INSURED PERSON HOSPITALIZED**

1	Name of the Patient:
2	Relationship with the Employee / Proposer <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Parent <input type="checkbox"/> Others _____
3	Date of Birth of Claimant: _____ Age : _____ Years Gender <input type="checkbox"/> Male <input type="checkbox"/> Female
4	Occupation: Service / Self Employed / Homemaker / Student / Retired / Others _____
Residential Address (if different from above)	
Address: _____	
City: _____ State: _____ Pincode: _____ Phone No: _____	

**DETAILS OF INSURANCE HISTORY:**

Currently do you have any other Medclaim/Health Insurance  Yes  No (if yes, provide other insurance details)

Date of commencement of first insurance without break: \_\_\_\_\_ (All previous policy copies to be enclosed)

Insurance Co. Name \_\_\_\_\_ Policy No: \_\_\_\_\_ Sum Insured \_\_\_\_\_

Have you been hospitalized in the last four years since inception of policy  Yes  No. If yes, please provide below details:

Date of Hospitalization: \_\_\_\_\_ Diagnosis: \_\_\_\_\_

Previously covered by any other Medclaim / Health Insurance  Yes  No

If Yes, Company Name \_\_\_\_\_

**DETAILS OF HOSPITALIZATION**

Name of Hospital where admitted: \_\_\_\_\_

Room Category occupied:  Day Care  Single Occupancy  Twin Sharing  3 or more Bed per Room  Others \_\_\_\_\_

Hospitalization due to  Injury  Illness  Maternity - Date of Injury / Date of Disease first Detected / Date of Delivery: \_\_\_\_\_

In case of accident / injury:  RTA  Intentional Self Injury. How did injury occur: \_\_\_\_\_

Date of Accident / Injury: \_\_\_\_\_ Reported to Police  Yes  No, if Medico Legal  Yes  No

FIR / MLC No: \_\_\_\_\_ FIR / MLC copy attached  Yes  No

Injury / Diseases caused due to Substance Abuse / Alcohol Consumption:  Yes  No. Test conducted to establish this  Yes  No

System of Medicine: \_\_\_\_\_

**DETAILS OF CLAIM**

Claimed Amount in Words: Rupees \_\_\_\_\_

Pre Hospitalization Period (in days): \_\_\_\_\_ Post Hospitalization Period (in days): \_\_\_\_\_

Details of the Treatment Expenses Claimed	Amount (Rs.)	Details of the Treatment Expenses Claimed	Amount (Rs.)
Pre Hospitalization Expenses		Health Check Up Cost	
Hospitalization Expenses		Ambulance Charges	
Post Hospitalization Expenses		Others	
Total Claimed Amount (Rs.):			

**DETAILS OF BILL ENCLOSED**

Sr. No	Bill No	Date	Issued by	Towards	Amount (Rs.)

**Details of Lumpsum / Cash Benefit Claimed:**

 Hospital Daily Cash Rs. \_\_\_\_\_ Surgical Cash Rs. \_\_\_\_\_ Critical Illness Benefit Rs. \_\_\_\_\_ Convalescence Rs. \_\_\_\_\_  
 Pre and Post Lumpsum Benefit Rs. \_\_\_\_\_ Others Rs. \_\_\_\_\_ Total Rs. \_\_\_\_\_

1. Diagnosis _____ 2. Admission Date: _____ Time : _____ 3. Discharge Date : _____ Time: _____ 4. Name of Treating Doctor: _____ 5. Mobile No. of Treating Doctor: _____ 6. Name of Family Physician: _____ 7. Mobile No. of Family Physician: _____	<b>Claim documents submitted - Check List:</b> <input type="checkbox"/> Claim Form duly signed <input type="checkbox"/> Copy of Claim Intimation Letter <input type="checkbox"/> Original Hospital Main Bill and Detailed Break Up <input type="checkbox"/> Original Hospital Bill Payment Receipt <input type="checkbox"/> Original Discharge Summary containing all relevant details <input type="checkbox"/> All Original Pharmacy Bills and their Receipts <input type="checkbox"/> Copies of all Investigation Reports & Prescriptions including OT Notes <input type="checkbox"/> First Prescription / Consultation Letter from your Doctor <input type="checkbox"/> Original Money Receipt duly signed with a Revenue Stamp <input type="checkbox"/> Copy of Proposer / Employee Photo ID Proof & Address Proof
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**CONSENT REQUIREMENT FOR ACCESS TO TREATMENT PAPERS / INDOOR CASE SHEETS / MEDICAL RECORDS / INVESTIGATOR VISIT**

I hereby authorize Future Generali India Insurance or any agency / individual authorized by them to obtain copies or review in person all my medical records including but not limited to admission notes, treatment sheets, indoor case papers, investigation reports, prescriptions and all other documents present in the hospital case file. Details related to my past hospitalisations in your hospital can also be provided / shown to Future Generali or its authorized representatives. I agree that all information provided above by me in the claim documents is true and that if I have provided any false or untrue information, my right to claim the reimbursement of expenses shall be absolutely forfeited.

 Name of Patient / Relative: \_\_\_\_\_  
 Relationship with Patient: \_\_\_\_\_  
 Signature of Patient / Relative: \_\_\_\_\_  
 Date: DD / MMM / YYYY

Please attach this form in Original to the hospital bill and other claim documents. 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**

*NEFT Transfers will be done only in special cases subject to Future Generali discretion*

Bank Name																															
Branch Name & Address																															
Branch Phone No.																															
Branch MICR Code																															
Branch IFSC Code for NEFT																															
( Please attach a Xerox copy of a cheque or a blank cheque of your bank duly cancelled for ensuring accuracy of the bank name, branch name and account number)																															
Account Type (Please Tick)	Savings					Current						Cash / Credit																			
Account No. (as appearing in Cheque Book)																															

Date from which the mandate should be effective: \_\_\_\_\_

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 updation of records for purpose of credit of claim amount through NEFT.

Name of Employee / Proposer: \_\_\_\_\_

Signature of Employee / Proposer: \_\_\_\_\_ 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 endeavour, 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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