



# FUTURE GENERALI INDIA

Insurance Company Limited

## FUTURE GENERALI GROUP PERSONAL ACCIDENT - CLAIM FORM

Policy No: \_\_\_\_\_ Claim no: \_\_\_\_\_  
Employee No: \_\_\_\_\_

### 1. Details of Insured/ Claimant

Name a) Insured/ Company : \_\_\_\_\_  
b) Claimant: \_\_\_\_\_

Address : \_\_\_\_\_

City: \_\_\_\_\_ Pin: \_\_\_\_\_

Occupation: \_\_\_\_\_ Date of birth: \_\_\_\_\_ Email ID: \_\_\_\_\_

Contact No: R: \_\_\_\_\_ Off: \_\_\_\_\_ Mobile: \_\_\_\_\_

### 2. Accident Details

Date & Time of accident / Occurrence: \_\_\_\_\_ Hrs. \_\_\_\_\_

Place & Location: \_\_\_\_\_

Description of accident /incidence: \_\_\_\_\_

### 3. Details of injuries sustained

In Case of Death:

Details of the Nominee - Name & Address: \_\_\_\_\_

Specify injured parts of the body: \_\_\_\_\_

Please specify nature of Disability : \_\_\_\_\_

Please mention Disability percentage in case of Permanent partial disablement:

Percentage: \_\_\_\_\_ (%) \_\_\_\_\_ (In words)

In case of Confinement/ Away from work: Period of confinement: From \_\_\_\_\_ To \_\_\_\_\_

Date of resuming duties \_\_\_\_\_

### 4. Has the Police been informed about the accident; If yes please give details

MLC No: \_\_\_\_\_ FIR No: \_\_\_\_\_

Name & Address of the Police station: \_\_\_\_\_

### 5. Was the injured person under the influence of alcohol/ drugs at the time of accident: YES/ NO

**6. Witnesses**

Name (s): \_\_\_\_\_

Address (s): \_\_\_\_\_  
\_\_\_\_\_

Contact No: R: \_\_\_\_\_ Off: \_\_\_\_\_ Mobile: \_\_\_\_\_

**7. Treatment Details**Casualty Doctor Name : \_\_\_\_\_  
Address : \_\_\_\_\_  
Tel no (s) : \_\_\_\_\_Family Doctor Name : \_\_\_\_\_  
Address : \_\_\_\_\_  
Tel no (s) : \_\_\_\_\_Hospital Details Name : \_\_\_\_\_  
Address : \_\_\_\_\_  
Tel no (s) : \_\_\_\_\_**8. Policy and Claims History**

A) Have you made any Claims in Past ? Yes No

B) If YES, Please give details including nature of Accident, Insurance details &amp; Claim amount

C) Are you insured under any other Policy ? Yes No

If YES, Please give full particulars (Name of company , Policy no, Period of insurance, Policy issuing office)

**Declaration**

I/We agree to provide additional information to the company, if required. I/we the above mentioned, do hereby, to the best of my/our knowledge and belief, warrant the truth of the foregoing statement in every respect, and if I/we have made, or in any further declaration the company may require in respect of the said accident, shall make any false or fraudulent statement, or suppress or conceal any material fact, the policy shall be void and all rights to recover compensation there under in respect of past, present or future accident shall be forfeited.

Place: \_\_\_\_\_

Date: \_\_\_\_\_

Signature of the insured

Group/Insured Stamp





I/We hereby to the best of my/our knowledge and belief, warrant the truth of the above details in every respect.

Doctor's Signature & Stamp:

Doctors Name :

Address and Tel. no

Date:

Regn No: