FUTURE GENERALI INDIA
Insurance Company Limited

FUTURE STUDENT SURAKSHA CLAIM FORM

Please contact our 24 hour Helpline (Europ Assistance Alarm Centre) as mentioned below in section –''HOW TO REACH US''.
Failure to intimate about 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 & exceptions of the insurance contract.
2. Please answer all questions completely. In case of insufficient space attach additional sheet.
3. Please attach all Originals bills, receipts, credit card slips to your claim.

1. Policy Number -	2. Policy Plan Type -
3. Policy Start Date -	4. Policy End date -
Please Indicate any 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) Present completed age -
(d) Occupation -	(e) Contact Number -
(e) Residential Address –	

Trip Details:-

Passport No: _____

Date of Departure: ____/____/_____ Flight No: _____ From _____ To _____

Date of Arrival: _____/_____/_____ Flight No: _____ From _____ To _____

Connective flight details (If any):

Date of Departure: ____/____/_____ Flight No: _____ From _____ To _____

Date of Arrival: _____/_____/_____ Flight No: _____ From _____ To _____

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. Personal Accident**	**C. Personal Care**
Medical Expenses ☐	Accidental Death ☐	Baggage Loss ☐
Repatriation of Remains ☐	Permanent Total Disability ☐	Delay of Checked In Baggage ☐
Emergency Medical Evacuation ☐	Accidental Death (Common Carrier) ☐	Compassionate Visit ☐
Emergency Sickness Dental Relief ☐		
Medical Treatment continued in India ☐		
Maternity Benefit ☐		
Mental & Nervous Disorder ☐		

D. Travel Inconvenience	**E. Special Care**	**F. Legal Liability**
Loss of Passport ☐	Tuition Fee ☐	Personal Liability. ☐
	Sponsor Protection ☐	
	Bail Bond ☐	
	Felonious Assault ☐	

MEDICAL EXPENSE COVERAGE, EMERGENCY DENTAL RELIEF, DAILY HOSPITALIZATION ALLOWANCE, EMERGENCY MEDICAL EVACUATION/REPATRIATION. MATERNITY BENEFIT. MENTAL DISORDER. TUITION FEE (Illness of Insured). COMPASSIONATE VISIT.

Medical Expenses ☐ **Tuition Fees** ☐

Name of the Hospital where treatment was given: _____

Address of the Hospital where treatment was given: _____

Name of Treating Doctor and Contact details: _____

Details of illness & Treatment: _____ Date of First Symptom ___/___/_____

Please confirm if the illness is suffered for first time or also treated in past (Pre-Existing): Yes ☐ No ☐

PAST MEDICAL HISTORY

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

Treatment Details of Any illness ailment in past: _____

Please provide name of any prescription medicine you are presently taking: _____

Name of Family Physician and contact details: _____

Claiming for Medical Evacuation Benefit then Reason of Medical Evacuation: _____

Place where Patient is to be evacuated: _____ Date of Medical Evacuation: _____

In case of Compassionate visit: Treating Doctor's opinion for the necessity of an attendant: _____

Documents Required: Discharge Summary, Investigation Reports, Doctors Certificate stating tooth/teeth treated, Doctors Certificate stating the reason for Medical Evacuation, Doctor's Certificate confirming the necessity of an attendant (compassionate visit), Medicine prescriptions & Bills, Bills and Receipts of expenses incurred:

ITEM NO	DETAILS OF EXPENSES INCURRED	AMOUNT

REPATRIATION OF MORTAL REMAINS

Cause of Death/ Medical Transportation: _____ Place of Death: _____

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

Documents Required: Death Certificate, Doctors Certificate for cause of death/Medical Transportation, Bills & Receipts of expenses incurred

ITEM NO	DETAILS OF EXPENSES INCURRED	AMOUNT

LOSS OF PASSPORT, BAGGAGE LOSS & BAGGAGE DELAY (CHECKED IN BAGGAGE)

Name of the Carrier: _____ Airport of Disembarkation _____

Date & Time of actual arrival: ____/____/_____ at _____ am/pm.

Date & Time of scheduled arrival ___/____/_____ at _____am/pm Total Hours of Delay _____

Date & Time of Retrieval of Baggage _____/_____/_____ at _____ am/pm.

Details of Incident i.e. how, when, where caused Travel inconvenience _____

_____

Date on which baggage/ passport was lost: ____/____/_____ Place where baggage/passport was lost _____

ITEM NO	DETAILS OF EXPENSES INCURRED	AMOUNT

PERSONAL ACCIDENT DEATH / DISABILITY of INSURED / FELONIOUS ASSAULT

Claiming for Personal Accident resulting into **DEATH** ☐ / **DISABILITY** ☐ (with 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 as per standard format)

BAIL BOND INSURANCE

Name of the Detaining Authority _____
Address & Contact no of Detaining Authority_____
Jurisdiction City _____ Legal Case No _____
Date of Loss_____Law of country allows bail for this Offence _ YES ☐ NO☐
Details of circumstances /Offence resulting in Detaining of Insured_____
_____

LEGAL / PERSONAL LIABILITY INSURANCE

Name of the Third Party to be compensated: _____
Date of Loss: _____Amount of Loss: _____Detail Circumstances of Loss i.e. how, when, where _____
_____
Name of the Police Station: _____ Police Information No_____
Legal Case No_____ Jurisdiction City _____

TUITION FEE / SPONSOR PROTECTION

Student Hospitalization for more than one month ☐ (Please fill details under Medical Expenses)

Accidental Death of immediate family Members ☐
Date of Accident: _____ Place of Accident: _____Claimed Amount: _____
Details & Circumstances of Accident i.e. how, when, where_____
_____
Was the deceased 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 deceased's Regular physician in India _____
Nominee Name, Address & Contact Details _____

(Please attach Attending Physician's Statement as per standard format)

ITEM NO	DETAILS OF EXPENSES INCURRED	AMOUNT

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: _____

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

HOW TO REACH US

Overseas policy holders can call us on any of the Toll free numbers listed below. All lines are accessible from Local Landline or payphone except for USA & Canada which are accessible from Mobile Phone

Country	Number to be dialed
USA	8775729854
Canada	8775729855
Russia	8-10-8002-7554011
New Zealand	00 +800-18001900
Singapore	001 +800-18001900
Malaysia	00 +800-18001900
Australia	0011+800-18001900
Austria	00 +800-18001900
China	00 +800-18001900
France	00 +800-18001900
Germany	00 +800-18001900
UK	00 +800-18001900
Netherlands	00 +800-18001900

Country	Number to be dialed
Belgium	00 +800-18001900
Portugal	00 +800-18001900
Denmark	00 +800-18001900
Hong Kong	00 +800-18001900
Norway	00 +800-18001900
Spain	00 +800-18001900
Finland	00 +800-18001900
Poland	00 +800-18001900
Thailand	00 +800-18001900
Ireland	00 +800-18001900
Philippines	00 +800-18001900
Italy	00 +800-18001900
Hungary	00 +800-18001900

In case there is no Toll free number for the country you are calling from, you may please call us on the our India Landline number - **+91 22 67347841** (This number is chargeable and accessible 24 X 7 X365). You may also ask for a call back on this number and we will immediately call you back on your preferred number as provided during the call request.

National Toll Free number for your relatives in India is **1800 209 2333.**

Alternatively, you may also write to us at fgi@europ-assistance.in / fgh.travel@futuregenerali.in.