FUTURE GENERALI
TOTAL INSURANCE SOLUTIONS

TOLL FREE PHONE: 1800 209 1016 / 1800 103 8889
TOLL FREE FAX: 1800 209 1017 / 1800 103 9998
E MAIL: fgh@futuregenerali.in

FGH-CF-02

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)	

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 ☐ Self ☐ Spouse ☐ Child ☐ Parent ☐ Others _____
3	Date of Birth of Claimant: _____ Age :_____ Years Gender ☐ Male ☐ 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 Mediclaim/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 Mediclaim / 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):_____

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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: _____

Claim documents submitted - Check List:

- ☐ Claim Form duly signed
- ☐ Copy of Claim Intimation Letter
- ☐ Original Hospital Main Bill and Detailed Break Up
- ☐ Original Hospital Bill Payment Receipt
- ☐ Original Discharge Summary containing all relevant details
- ☐ All Original Pharmacy Bills and their Receipts
- ☐ Copies of all Investigation Reports & Prescriptions including OT Notes
- ☐ First Prescription / Consultation Letter from your Doctor
- ☐ Original Money Receipt duly signed with a Revenue Stamp
- ☐ Copy of Proposer / Employee Photo ID Proof & Address Proof

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.

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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.
