

**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)

POLICY / INSURED DETAILS

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 _____

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): |

CLAIMANT / PATIENT DETAILS

| | |
|---|---|
| 1 | Name of the Patient: |
| 2 | Relationship with the Employee / Proposer <input type="radio"/> Self <input type="radio"/> Spouse <input type="radio"/> Child <input type="radio"/> Parent <input type="radio"/> Others _____ |
| 3 | Date of Birth of Claimant: _____ Age _____ Years Gender <input type="radio"/> Male <input type="radio"/> Female |
| 4 | Residential Address |

CLAIM DETAILS

Total Claimed Amount: ₹

Claimed Amount in Words: Rupees (₹) _____

1. Diagnosis _____
2. Admission Date: _____ Discharge Date : _____
3. Name of Treating Doctor: _____
4. Mobile No. of Treating Doctor: _____
5. Name of Family Physician: _____
6. Mobile No. of Family Physician: _____

Enclosure Check List :

1. Original Discharge Summary containing all relevant details
2. All Original Bills and their Receipts
3. Copies of all Reports & prescriptions
4. First Prescription / Consultation Letter from your Doctor.
5. Original Money Receipt duly signed with a Revenue Stamp.
6. 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 / MM / 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.
