

10. Have the Police been informed about the accident? YES NO

If yes, please give following details and submit the FIR and Medico Legal Certificate (MLC) along with claim documents.

MLC No: _____ FIR No: _____

Name & Address of the Police Station: _____

11. Please provide following details of CASUALTY DOCTOR (*Doctor who has first treated the patient after the accident*)

Doctor Name: _____

Hospital / Clinic Name: _____

Hospital / Clinic Address: _____

Contact No: _____

DETAIL OF OTHER HEALTH / PERSONAL ACCIDENT POLICIES AND CLAIMS

12. Are you insured under any other Policy? YES NO

(If yes, Please provide following details)

Name of the Insurance Company: _____

Policy No: _____

Period of Insurance: _____

Policy Issuing Office: _____

Have you made any Claims in Past? YES NO

(If yes, please provide details including)

Nature of Accident: _____

Claim Amount: _____

DECLARATIONS

I/ We _____ hereby declare that the details given above are true and correct to the best of my/our belief and knowledge. In event above information or any part thereof is found incorrect, I/We agree that all rights under the policy will be forfeited. I/We also agree to provide additional information to the company, if required.

Date: _____

Place: _____

Signature of Insured/ Nominee

ATTENDING PHYSICIAN'S STATEMENT

(To be filled completely and signed by Attending Physician only. Incomplete Statement will lead to closure of claim)

1. Name of Injured Person: _____ 2. Age of Injured Person: _____
3. Date of Accident: _____ (DD / MM / YY) Time of Accident: _____ (AM / PM)
4. History and Alleged Cause of Injury:

5. Nature of the Accident, Clinical Details of Injuries Sustained:

6. Provisional Diagnosis: _____
7. Does the Cause of Accident as stated by the Claimant tally as per your opinion? YES NO
8. Are the injuries solely due to the accident? YES NO

If yes, please provide the injury certificate: _____
9. Please specify exact anatomical site and extent of injury: _____
10. Do the injuries appear fresh or old: FRESH OLD
11. Please confirm probable duration since when the injury was sustained: _____
12. Was the Injured Person suffering from any disease or injury which may have contributed to the accident or likely to aggravate his condition? YES NO
13. Was the claimant hospitalized? YES NO

If yes, then please provide period of hospitalization: From: _____ To: _____
14. What treatment/ procedure/ operations were performed? _____

15. Was he/she under the influence of intoxicants or drugs at the time of accident? YES NO
16. Are you his Family Doctor? YES NO

If you have treated him for any previous illness or injury, please provide details

17. Has this accident been reported to the Police Authorities? YES NO

MLC No: _____ FIR No: _____

Name & Address of the Police Station: _____
12. Please specify nature of Disability: _____
13. In case of Permanent Partial Disablement: Please mention Disability Percentage

Percentage: _____ (%) _____ (In words)

14. How long was or will the claimant be totally disabled? From: _____ To: _____

Doctor's Name: _____ Signature: _____

Address and Contact No: _____

Date: _____ Registration Number: _____

AUTHORIZATION FOR TRANSFER OF CLAIM AMOUNT BY NATIONAL ELECTRONIC FUND TRANSFER (NEFT)

Future Generali India Insurance Company Limited

Claim Correspondence Address Future Generali Health, Office No. 3, 3rd Floor, "A" Building, G - O - Square, Near Mankar Chowk, Aundh Hinjewadi Link Road, Wakad, Pune - 411 057

Corporate Identity No (CIN): U66030MH2006PLC165287 Toll Free: 1800 209 1016 / 1800 103 8889 (Health - Phone) | 1800 209 1017 / 1800 103 9998 (Health - Fax) Email: fgh@futuregenerali.in Website address www.futuregenerali.in

FGH-PACF-01

Please attach any of the following documents carrying the required information (In case of Group Personal Accident policy, NEFT is to be provided only if the beneficiary is employee or individual)

Document List (Any One of the Following)	Required Information on the Document Submitted
1. Photocopy of cheque with printed name of Proposer / Employee / Nominee (in case of death)	1. Name of Proposer / Employee / Nominee (in case of death)
2. Bank Passbook	2. Bank Account Number
3. Bank Statement	3. Bank Account Type
4. Duly filled NEFT form authorized by the bank	4. IFSC Code
	5. Bank Name & Branch name

I hereby declare that in case of a Group Personal Accident Policy, the claim amount shall be paid as per the beneficiary defined in the Group Policy. I hereby declare that the particulars given by me are correct and complete and request you to remit any amount due to me, if any to the provided bank account as per document submitted by me. I herewith further declare that if any transaction is delayed or not effected at all or is wrongly credited to any other account for reasons of incomplete or incorrect information as provided by me, I shall not hold Future Generali India Insurance Company Ltd ("Company") or any of its directors, employees or agents responsible for the same. I also declare that the remittance of any dues to the provided bank account shall be considered as full and valid discharge of its obligations by the company. I also undertake to advise any change in the particulars of my bank account to facilitate updation of records for the purpose of credit of any amount due, through NEFT.

Name of Employee / Proposer: _____

Signature of Employee / Proposer: _____

Claimant Name: _____

Date: _____ Place: _____

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 endeavor, 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.
