FUTURE GENERALI
TOTAL INSURANCE SOLUTIONS

CLAIM FORM
SHUBH YATRA

Please contact our 24 hour Helpline Number **+91 22 67347841**. Failure to intimate 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 & exclusions of policy.
2. Please attach all Originals bills, receipts, credit card slips or bank statement to your claim. (Mandatory)

1. Policy Number -	
2. Policy Start Date -	3. Policy End date -
Please Indicate any other insurance coverage (In India/overseas) -	**Policy Number/s :**
Name of the Policyholder:	
4. Name of the Insured Person/Member	
5. (a) Name of the Claimant Person (in respect of whom the claim is made)	
(b) Relationship to the Insured -	(c) E-mail ID/s :-
(d) Contact Numbers -	
(e) Residential Address –	

Trip Details: -
Date of Departure: ____/____/_____ Mode of Travel: _____ Flight/ Train No: _____
From_____ To _____
Date of Arrival: _____/_____/_____ Mode of Travel: _____ Flight/ Train No: _____
From _____ To _____

Claim in Respect of following section (*please tick against the applicable claim type*)

Accidental Death	☐	Home Insurance	☐	Missed connections	☐
Permanent Total Disability	☐	Bag Insurance	☐	Loss of Checked in baggage	☐
Permanent Partial Disability	☐	Trip Cancellation	☐	Bounced Hotel and Flight	☐
Accidental Hospitalisation	☐	Trip Curtailment	☐	Emergency Hotel Extension	☐
Emergency Evacuation and Repatriation of Remains	☐	Trip Delay	☐		

ACCIDENTAL HOSPITALISATION/ EMERGENCY EVACUATION

Name of the Hospital: _____

Address of the Hospital: _____

Name of Treating Doctor and Contact details: _____

Details of accident & Treatment: _____

Date of First Symptom ____/____/_____ please confirm if the illness was also treated in past (Pre-Existing): Yes ☐ No ☐

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

Treatment Details of Any illness ailment in past: _____

Name of medicines you are presently or routinely taking: _____

PAST HISTORY OF ANY CHRONIC ILLNESS WITH DURATION					
Disease / Ailment					**Duration (Specify Years / Months / Days)**
Hypertension	Yes		No		
Hyperlipidemia	Yes		No		
Cancer	Yes		No		
Osteoarthritis	Yes		No		
Diabetes	Yes		No		
Cardiovascular Diseases	Yes		No		
Asthma / COPD / Bronchitis	Yes		No		
Congenital Internal / External	Yes		No		
Any HIV or STD/Related Ailments	Yes		No		
Alcohol or Drug Abuse	Yes		No		
Any Surgery / Hospitalization	Yes		No		
Any Other Disease / Disability	Yes		No		

Name of Family Physician: _____
Email ID and contact details of Family Physician: _____

Please provide reasons for Evacuation) _____
_____

(PLEASE ATTACH TREATING DOCTOR'S OPINION FOR THE NECESSITY OF AN ATTENDANT/EVACUATION).

Evacuation Request From: - _____ to: -_____

Date of Medical Evacuation required: _____

REPATRIATION OF REMAINS

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

ITEM NO	DETAILS OF EXPENSES INCURRED – UNDER MEDICAL EXPENSES	AMOUNT
TOTAL CLAIMED AMOUNT * Kindly specify this total claimed amount.		

LOSS OF BAGGAGE/ TRIP DELAY/ TRIP CURTAILMENT

Date & Time of actual arrival: ____/____/_____ at _____ am/pm. Date & Time of scheduled arrival ___/____/_____ at _____am/pm,

Date & Time of Retrieval of Baggage_____/_____/_____ at _____ am/pm, Total Hours of Delay _____

Details of Incident i.e. how, when, where _____

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

ITEM NO	DETAILS OF EXPENSES INCURRED – UNDER TRIP DELAY/ TRIP CURTIALMENT	AMOUNT
TOTAL CLAIMED AMOUNT * Kindly specify this total claimed amount.		

PERSONAL ACCIDENT

Claiming for Personal Accident resulting into **DEATH** ☐ / **DISABILITY** ☐ (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)

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 to the presence or future shall be forfeited.

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

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

HOW TO REACH US

You may please call us on our India Landline number - +91 22 67347841 (This number is chargeable and accessible 24 X 7 X 365). 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 is 1800-209-2333.

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