FUTURE GENERALI
TOTAL INSURANCE SOLUTIONS

Travel Insurance Claim Form

Please contact our 24 hour Helpline Number **+91 22 67347841** (with call back facility anywhere in the world) **OR** You may use Country specific numbers as mentioned below in–**''HOW TO REACH US''**. 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. Passport No-
3. Policy Start Date -	4. Policy End date -
Please Indicate any other 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) E-mail ID/s :-
(d) Contact Numbers (INDIA) -	(e) Contact Numbers(Overseas) -
(e) Residential Address (INDIA) –	

Trip Details: - 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. Travel Inconvenience**	**C. Personal Care**
Medical Expenses ☐	Hijack Benefit ☐	Baggage Loss (Checked in Baggage) ☐
Repatriation of Remains ☐	Trip Delay ☐	Baggage Delay (Checked in Baggage) ☐
Emergency Medical Evacuation ☐	Trip Cancellation ☐	Compassionate Visit ☐
Daily Hospital Allowances ☐	Trip Curtailment ☐	Financial Emergency Assistance ☐
Emergency Sickness Dental Relief ☐	Missed Connection	
Continuation of Medical Treatment in India ☐	Loss of Passport	

D. Personal Accident	**E. Special Care**	**F. Legal Liability**
Accidental Death.	Golfers Hole in one Celebration ☐	Personal Liability ☐
Permanent Total Disability.	Home Burglary Insurance ☐	
Accidental Death (Common Carrier) ☐	Automatic extension of policy period ☐	
Accidental Death (Air Travel Only) ☐	Child Return Journey ☐	

MEDICAL EXPENSES, EMERGENCY SICKNESS DENTAL RELIEF, EMERGENCY MEDICAL EVACUATION

Name of the Hospital: ____________________

Address of the Hospital: ____________________

Name of Treating Doctor and Contact details: ____________________

Details of illness& 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 (INDIA): ____________________

Email ID and contact details of Family Physician (INDIA):____________________

If, Claiming for Medical Evacuation / Compassionate visit then Reasons for Medical 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

Cause of Death/ Medical Transportation:____________________Place of Death: ____________________

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.		

FINANCIAL EMERGENCY ASSISTANCE

Date on which fund was lost:____/____/_____Details of incident of loss of fund i.e. how, when, where____________
____
____

Local contact Person (INDIA) who can provide payment security____________Contact Numbers ________________

Name of the Police Station________________Police Information (FIR) No _____________________________

LOSS OF PASSPORT, LOSS OF BAGGAGE; DELAY IN CHECKED IN BAGGAGE, TRIP DELAY/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/passport was lost:____/_____/_____Place where baggage/passport was lost ____________

ITEM NO	DETAILS OF EXPENSES INCURRED – UNDER TRAVEL INCOVENIENCE	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)

PERSONAL ACCIDENT DEATH / DISABILITY of INSURED / SPONSOR

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

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 of the presence or future shall be forfeited.

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

Date:____________________________ **Name 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
Argentina	0080055331345
Australia	001180055331345
Austria	0080055331345
Belgium	0080055331345
Canada	01180055331345
China	0080055331345
Czech Republic	0080055331345
Denmark	0080055331345
France	0080055331345
Germany	0080055331345
Greece	86002038016
Hong Kong	00180055331345
Hungary	0080055331345
Italy	0080055331345
Japan	01080055331345
Malaysia	0080055331345
Netherlands	0080055331345
New Zealand	0080055331345
Norway	0080055331345
Philippines	0080055331345
Poland	0080055331345
Portugal	0080055331345
Singapore	00180055331345
South Africa	0080055331345
Spain	0080055331345
Sweden	0080055331345
Switzerland	0080055331345
Taiwan	0080055331345
Thailand	00180055331345
United Kingdom	0080055331345
USA	18337426672

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.