

# 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 -              |
| <b>Please Indicate any other insurance coverage (In India/overseas) - Policy Number/s :</b> |                                   |
| 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)**

|  |  |   |
|--|--|---|
| <b>A. Medical Care</b><br>Medical Expenses <input type="checkbox"/><br>Repatriation of Remains <input type="checkbox"/><br>Emergency Medical Evacuation <input type="checkbox"/><br>Daily Hospital Allowances <input type="checkbox"/><br>Emergency Sickness Dental Relief <input type="checkbox"/><br>Continuation of Medical Treatment in India <input type="checkbox"/> | <b>B. Travel Inconvenience</b><br>Hijack Benefit <input type="checkbox"/><br>Trip Delay <input type="checkbox"/><br>Trip Cancellation <input type="checkbox"/><br>Trip Curtailment <input type="checkbox"/><br>Missed Connection <input type="checkbox"/><br>Loss of Passport <input type="checkbox"/> | <b>C. Personal Care</b><br>Baggage Loss <input type="checkbox"/><br>Baggage Delay <input type="checkbox"/><br>Compassionate Visit <input type="checkbox"/><br>Financial Emergency Assistance <input type="checkbox"/> |
|--|--|---|

|  |   |  |
|--|---|--|
| <b>D. Personal Accident</b><br>Accidental Death. <input type="checkbox"/><br>Permanent Total Disability. <input type="checkbox"/><br>Accidental Death (Common Carrier) <input type="checkbox"/><br>Accidental Death (Air Travel Only) <input type="checkbox"/> | <b>E. Special Care</b><br>Golfers Hole in one Celebration <input type="checkbox"/><br>Burglary (Home Contents) <input type="checkbox"/> | <b>F. Legal Liability</b><br>Personal Liability <input type="checkbox"/> |
|--|---|--|

**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 confirms 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 |
|---------|---|--------|
|         |   |        |
|         |   |        |
|         |   |        |
|         |   |        |





**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 <input type="checkbox"/> Current <input type="checkbox"/> Cash / Credit <input type="checkbox"/> |                  |
| Contact numbers in India: _____ ; _____ ; Alternate Email ID: _____   |                  |
| <b>( Please attach a scanned image of a blank , duly cancelled cheque - of your bank)</b>                               |                  |

**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 the presence or future shall be forfeited.

Place: \_\_\_\_\_

Signature of the claimant/ Insured

Date: \_\_\_\_\_

Name of the claimant/ Insured

