

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 Medical Expenses <input type="checkbox"/> Repatriation of Remains <input type="checkbox"/> Emergency Medical Evacuation <input type="checkbox"/> Daily Hospital Allowances <input type="checkbox"/> Emergency Sickness Dental Relief <input type="checkbox"/> Continuation of Medical Treatment in India <input type="checkbox"/>	B. Travel Inconvenience Hijack Benefit <input type="checkbox"/> Trip Delay <input type="checkbox"/> Trip Cancellation <input type="checkbox"/> Trip Curtailment <input type="checkbox"/> Missed Connection <input type="checkbox"/> Loss of Passport <input type="checkbox"/>	C. Personal Care Baggage Loss <input type="checkbox"/> (Checked in Baggage) Baggage Delay <input type="checkbox"/> (Checked in Baggage) Compassionate Visit <input type="checkbox"/> Financial Emergency Assistance <input type="checkbox"/>
D. Personal Accident Accidental Death. <input type="checkbox"/> Permanent Total Disability. <input type="checkbox"/> Accidental Death (Common Carrier) <input type="checkbox"/> Accidental Death (Air Travel Only) <input type="checkbox"/>	E. Special Care Golfers Hole in one Celebration <input type="checkbox"/> Home Burglary Insurance <input type="checkbox"/> Automatic extension of policy period <input type="checkbox"/> Child Return Journey <input type="checkbox"/>	F. Legal Liability 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 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)	
	Yes	No		
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 FUNDPlease 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 2267347841 (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 / fgi.travel@futuregenerali.in.



Future Generali India Insurance Company Limited

Regd. and Corp. Office: Indiabulls Finance Centre, Tower 3, 6th Floor, Senapati Bapat Marg, Elphinstone, Mumbai - 400013.
Call us at: 1800-220-233 / 1860-500-3333 / 022-67837800 | Fax No: 022 4097 6900. Website:
<https://general.futuregenerali.in> | Email: fgicare@futuregenerali.in
IRDAI Regn. No. 132 | CIN: U66030MH2006PLC165287 | Service Tax Registration No.: AABCF091RSD002