FUTURE GENERALI
TOTAL INSURANCE SOLUTIONS

TOLL FREE PHONE: 1800 103 8889
TOLL FREE FAX: 1800 103 9998
E MAIL: fgh@futuregenerali.in

HEALTH INSURANCE CLAIM FORM

ALL FIELDS IN THIS FORM ARE MANDATORY AND THE CLAIM WILL BE NOT BE PROCESSED IF ANY OF THE DETAILS ARE MISSING

Claim Number (For FGH Use Only)	

POLICY / INSURED DETAILS

Policy No : _____ Health Card No. of Patient _____

Policy Start Date _____ Policy End Date _____ Date of Joining the Policy _____

Corporate Name : _____(Only for Group Policies) Employee ID _____

PERSONAL DETAILS OF EMPLOYEE/PROPOSER

1	Name of the Employee / Individual:
2	E-Mail address of the Employee/Individual:
3	Mobile No:
4	Permanent Account Number (PAN):

CLAIMANT / PATIENT DETAILS

1	Name of the Patient:	
2	Relationship with the Employee / Proposer	◯ Self ◯ Spouse ◯ Child ◯ Parent ◯ Others _____
3	Date of Birth of Claimant: _____ Age _____ Years Gender ◯ Male ◯ Female	
4	Residential Address	

CLAIM DETAILS

Total Claimed Amount: `							

Claimed Amount in Words: Rupees (`)_____

1. Diagnosis _____
2. Admission Date: _____Discharge Date : _____
3. Name of Treating Doctor: _____
4. Mobile No. of Treating Doctor: _____
5. Name of Family Physician: _____
6. Mobile No. of Family Physician: _____

Enclosure Check List :

1. Original Discharge Summary containing all relevant details
2. All Original Bills and their Receipts
3. Copies of all Reports & prescriptions
4. First Prescription / Consultation Letter from your Doctor.
5. Original Money Receipt duly signed with a Revenue Stamp.
6. Copy of Proposer/Employee Photo ID Proof & Address Proof

CONSENT REQUIREMENT FOR ACCESS TO TREATMENT PAPERS / INDOOR CASE SHEETS / MEDICAL RECORDS / INVESTIGATOR VISIT

I hereby authorize Future Generali India Insurance or any agency / individual authorized by them to obtain copies or review in person all my medical records including but not limited to admission notes, treatment sheets, indoor case papers, investigation reports, prescriptions and all other documents present in the hospital case file. Details related to my past hospitalisations in your hospital can also be provided / shown to Future Generali or its authorized representatives. I agree that all information provided above by me in the claim documents is true and that if I have provided any false or untrue information, my right to claim the reimbursement of expenses shall be absolutely forfeited.

Name of Patient / Relative: _____

Relationship with Patient: _____

Signature of Patient / Relative: _____

Date: DD / MM / YYYY

FUTURE GENERALI Health

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Please attach this form in Original to the hospital bill and other claim documents. Separate claim form required for each claim. PLEASE ENCLOSE A PHOTOCOPY OF THE FUTURE GENERALI HEALTH ID CARD.

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 endeavour, 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.