

**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)	
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DETAILS OF PRIMARY INSURED

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 _____	
1	Name of the Employee / Individual:
2	E-Mail address of the Employee/Individual:
3	Mobile No:
4	Permanent Account Number (PAN):
Address: _____	
City: _____ State: _____ Pincode: _____ Phone No: _____	

DETAILS OF INSURED PERSON HOSPITALIZED

1	Name of the Patient:
2	Relationship with the Employee / Proposer <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Parent <input type="checkbox"/> Others _____
3	Date of Birth of Claimant: _____ Age : _____ Years Gender <input type="checkbox"/> Male <input type="checkbox"/> Female
4	Occupation: Service / Self Employed / Homemaker / Student / Retired / Others _____
Residential Address (if different from above)	
Address: _____	
City: _____ State: _____ Pincode: _____ Phone No: _____	

DETAILS OF INSURANCE HISTORY:

Currently do you have any other Medclaim/Health Insurance Yes No (if yes, provide other insurance details)

Date of commencement of first insurance without break: _____ (All previous policy copies to be enclosed)

Insurance Co. Name _____ Policy No: _____ Sum Insured _____

Have you been hospitalized in the last four years since inception of policy Yes No. If yes, please provide below details:

Date of Hospitalization: _____ Diagnosis: _____

Previously covered by any other Medclaim / Health Insurance Yes No

If Yes, Company Name _____

DETAILS OF HOSPITALIZATION

Name of Hospital where admitted: _____

Room Category occupied: Day Care Single Occupancy Twin Sharing 3 or more Bed per Room Others _____

Hospitalization due to Injury Illness Maternity - Date of Injury / Date of Disease first Detected / Date of Delivery: _____

In case of accident / injury: RTA Intentional Self Injury. How did injury occur: _____

Date of Accident / Injury: _____ Reported to Police Yes No, if Medico Legal Yes No

FIR / MLC No: _____ FIR / MLC copy attached Yes No

Injury / Diseases caused due to Substance Abuse / Alcohol Consumption: Yes No. Test conducted to establish this Yes No

System of Medicine: _____

DETAILS OF CLAIM

Claimed Amount in Words: Rupees _____

Pre Hospitalization Period (in days): _____ Post Hospitalization Period (in days): _____

Details of the Treatment Expenses Claimed	Amount (Rs.)	Details of the Treatment Expenses Claimed	Amount (Rs.)
Pre Hospitalization Expenses		Health Check Up Cost	
Hospitalization Expenses		Ambulance Charges	
Post Hospitalization Expenses		Others	
Total Claimed Amount (Rs.):			

DETAILS OF BILL ENCLOSED

Sr. No	Bill No	Date	Issued by	Towards	Amount (Rs.)

Details of Lumpsum / Cash Benefit Claimed:

Hospital Daily Cash Rs. _____ Surgical Cash Rs. _____ Critical Illness Benefit Rs. _____ Convalescence Rs. _____

Pre and Post Lumpsum Benefit Rs. _____ Others Rs. _____ Total Rs. _____

1. Diagnosis _____ 2. Admission Date: _____ Time : _____ 3. Discharge Date : _____ Time: _____ 4. Name of Treating Doctor: _____ 5. Mobile No. of Treating Doctor: _____ 6. Name of Family Physician: _____ 7. Mobile No. of Family Physician: _____	Claim documents submitted - Check List: <input type="checkbox"/> Claim Form duly signed <input type="checkbox"/> Copy of Claim Intimation Letter <input type="checkbox"/> Original Hospital Main Bill and Detailed Break Up <input type="checkbox"/> Original Hospital Bill Payment Receipt <input type="checkbox"/> Original Discharge Summary containing all relevant details <input type="checkbox"/> All Original Pharmacy Bills and their Receipts <input type="checkbox"/> Copies of all Investigation Reports & Prescriptions including OT Notes <input type="checkbox"/> First Prescription / Consultation Letter from your Doctor <input type="checkbox"/> Original Money Receipt duly signed with a Revenue Stamp <input type="checkbox"/> Copy of Proposer / Employee Photo ID Proof & Address Proof
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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 / MMM / YYYY

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.

