FUTURE GENERALI INDIA
Insurance Company Limited

FUTURE GENERALI GROUP HEALTH - CLAIM FORM

(Issuance of this form does not imply acceptance of the liability)

Note: Every field should be answered in detail

1. Claim Number	
2. Policy Number	
3. Group Corporate Name	
4. Employee ID Number	
5. Employee Name	
6. Sum Insured Entitled	
7. Customer ID number – mentioned on health card	
8. (a) Name of the claimant person (in respect of whom the claim is made)	
(b) Relationship to the employee	
(c) Present completed age	
(d) Occupation	
(e) Residential Address	
9. Nature of disease/illness contracted or injury suffered or complete diagnosis	
10. Date of injury sustained/ or disease/illness first detected	
11. Details of Pre existing disease/ illness with duration of disease/ illness (if any)	
12. Past history of any related surgery with date of surgery.	
13. (a) Name and address of attending medical practitioner	
(b) Qualification / Degree	
(c) Registration no	
(d) Contact No	
14. (a) Name and address of Hospital/ Nursing Home/ Clinic (where patient hospitalized or treatment taken)	
(b) Registration no of the Hospital	
(c) Date of admission	
(d) Date of discharge	

15. Nature of the claim (*Please indicate by tick mark)*			
A) Type of claim	Hospitalization ☐	Pre Hospitalization ☐	Post Hospitalization ☐
B) Type of provider	Network ☐	Non Network ☐	
C) Type of admission	Emergency ☐	Planned ☐	Daycare ☐

16. Schedule of expenses incurred by the claimant under hospitalization (to be supported by original bills/receipts, cash memos, etc)

	Expenses incurred in the hospital	Pre hospitalization expenses (Rs)	Post hospitalization expenses (Rs)
Hospitalization Benefit			

In support of the above claim, I enclose following documents in Original (*Please indicate by tick mark*)	
1. Final Hospital Bill with Receipt	
2. Discharge certificate/card from the Hospital	
3. Cash Memos from, the Hospital/Chemist(s), supported by proper prescription	
4. Receipt and Pathological test report from a Pathologist supported by the note from the attending Medical Practitioner/Surgeon demanding such Pathological test.	
5. Surgeon's certificate stating nature of operation performed and Surgeon's bill and receipt	
6. Attending Doctor's / Consultant's / Specialist's / Anesthetist's bill and receipt and certificate regarding diagnosis.	
7. Certificate from the attending Medical Practitioner /Surgeon that the patient is fully cured.	

NOTE: Submit the Medical Certificate signed and stamped by attending doctor in attached format.

I hereby warrant the truth of the foregoing particulars in every respect and I agree that if I have made or shall make any false or untrue statement suppression or concealment my right to claim reimbursement of the said expenses shall be absolutely forfeited. I further declare that in respect of the above treatment no benefits are admissible under any other Medical Scheme of insurance. I consent and authorize the insurers to seek medical information from any Hospital/Medical Practitioner who has at any time attended concerning the claim.

Date: **Signature of Claimant**

FUTURE GENERALI

MEDICAL CERTIFICATE TO BE FILLED IN BY THE DOCTOR TREATING THE PATIENT

1	Name of the Patient			Age	Yrs	Months
2	Hospitalization Period	Date of Admission		Date of Discharge		
3	Diagnosis					
4	Date of first consultation (prior to hospitalization)					
5	Presenting complaints on admission					
6	Since when was the patient suffering from these complaints?					
7	Past history of the patient, if any with duration of the ailment/s					
8	Whether the present ailment is a complication of any pre existing ailment or previous surgery?		Yes	No		
9	If yes , please specify the disease or surgery and details thereof					
10	Whether the disease/defect/disorder is congenital in nature					
11	Nature of treatment given or surgery performed for present ailment/injury					
12	If the claim is for maternity or related condition, number of living children excluding the new born					
13	In case of accidental injury, insured was under influence of alcohol		Yes	No		
14	In case of accidental injury, FIR done		Yes	No		

DATE: _____ **Name of the Doctor: _____**

Signature of the Doctor with Seal