FUTURE TRAVEL SURAKSHA CLAIM FORM

FUTURE GENERALI
TOTAL INSURANCE SOLUTIONS

Please contact our 24 hour Helpline (Europ Assistance) on Phone No : +91 22 6734 7878 & Fax: +91 22 6734 7888

Failure to call our Assistance Company on 24 hour helpline in respect of Medical & Accident claims shall invalidate your claim.

Note:

1. Issuance of the form does not imply acceptance of the liability or a waiver of terms, conditions & exceptions of the insurance contract.
2. This is a One Call Claim Form, except for Accidental Death & Disability, Burglary, Hijack Distress Allowance and Personal Liability; we shall provide a separate Claim Form
3. Please answer all questions completely. In case of insufficient space attach additional sheet.
4. Please attach all bills, receipts, credit card slips to your claim.

1. Policy Number		2. Policy Plan Type	
3. Policy Start Date		4. Policy End date	
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) Present completed age	
(d) Occupation		(e) Contact Number	
(e) Residential Address			

7. Trip Details:

Date of Departure: ___/___/_____ Flight No: _____ From _____ To _____
Date of Arrival: ___/___/_____ Flight No: _____ From _____ To _____
Passport No: _____

8. Claim is Respect of following section (please tick against the claim type)

A. Medical Care		B. Travel Inconvenience		C. Personal Care	
Medical Expense	☐	Hijack Distress Allowance	☐	Baggage Loss	☐
Repatriation of Remains	☐	Trip Delay	☐	Baggage Delay	☐
Medical Transportation	☐	Trip Cancellation	☐	Compassionate Visit	☐
Emergency Medical Evacuation	☐	Trip Curtailment	☐	Financial Emergency Assistance	☐
Balance Period of Policy	☐	Missed Connection	☐		
Daily Allowance in case of Hospitalization	☐	Loss of Passport	☐		
Emergency Sickness Dental Relief	☐				

MEDICAL EXPENSE COVERAGE, EMERGENCY SICKNESS DENTAL RELIEF, EMERGENCY MEDICAL EVACUATION, DAILY ALLOWANCE DURING HOSPITALIZATION & COMPASSIONATE VISIT

Name of the Hospital where treatment was given: _____
Address of the Hospital where treatment was given: _____
Name of Treating Doctor: _____
Details of illness/ disease/ailment: _____

Date of Onset of illness/ disease/ ailment: ___/___/_____
If the illness/disease/ailment is pre-existing/ aggravated due to pre-existing condition, mention the details: _____
_____
Treatment Date: From __/___/_____ To ___/___/_____
Treatment Details: _____

Reason of Medical Evacuation: _____
Place where Patient is evacuated: _____ Date of Medical Evacuation: _____
Claiming for Daily Hospitalization Cash Allowance: YES / NO

In case of Compassionate visit:
Treating Doctor's opinion for the necessity of an attendant: _____
Documents Required: Discharge Summary, Investigation Reports, Doctors Certificate stating tooth/teeth treated, Doctors Certificate stating the reason for Medical Evacuation, Doctor's Certificate confirming the necessity of an attendant (compassionate visit), Medicine prescriptions & Bills, Bills and Receipts of expenses incurred:

Item No	Details of Expenses Incurred	Amount

REPATRIATION OF REMAINS & MEDICAL TRANSPORTATION

Cause of Death/ Medical Transportation: _____
Place of Death: _____
Medical Transportation from _____ to _____ Date of Death/ Medical Transportation: ___/__/_____

Documents Required: Death Certificate, Doctors Certificate for cause of death/ Medical Transportation, Bills & Receipts of expenses incurred:

Item No	Details of Expenses Incurred	Amount

TRIP DELAY, TRIP CANCELLATION, TRIP CURTAILMENT & MISSED CONNECTION

Claim Type: Trip Delay / Trip Cancellation / Trip Curtailment / Missed Connection

Name of the carrier: _____
Date & Time of actual arrival: ___/___/_____ at _____ am/pm. Date & Time of scheduled arrival: __/___/_____ at ____am/pm
Date & Time of departure for connecting flight: ___/___/_____ at ____am/pm
Details of Reason/ Incident due to which Trip was Delayed/Cancelled/Curtailed/Missed connection: _____

Date & Time of Incident: __/__/_____ at ____ am/pm. Person affected of incident: Claimant/ Family Member
Name of the family member affected: _____ Relationship of affected person with claimant: _____
Address of affected person: _____

Documents Required: Carrier Authority Report stating the reason for delay (if carrier was delayed), Medical report (if family member is suffering from critical illness), Death Certificate (if family member is dead), Bills & Receipts for expenses incurred:

Item No	Details of Expenses Incurred	Amount

LOSS OF PASSPORT, BAGGAGE LOSS & BAGGAGE DELAY (CHECKED IN BAGGAGE)

Name of the Carrier: _____

In case of baggage loss/ loss of passport:
Date on which baggage/ passport was lost: ___/___/_____ Place where baggage/passport was lost: _____

In case of baggage delay:
Date & Time of Arrival: ____/____/_____ at _____ am/pm. Airport of Disembarkation: _____
Date & Time of Retrieval of Baggage: _____/_____/_____ at _____ am/pm

Documents Required: Police report made within 24 hrs of loss of passport, Property irregularity report, Airport authority report stating the compensation received for lost baggage, Bills & Receipts as a proof of ownership of for items lost with baggage, Bills of items purchased in emergency due to baggage loss:

Item No	Details of Expenses Incurred	Amount

FINANCIAL EMERGENCY ASSISTANCE

Date on which fund was lost: ____/____/_____
Details of reason for loss of fund: _____
_____

Documents Required: Police report made within 24 hrs of loss.

DECLARATION

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 made already 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:
Date:

Signature of the claimant/ Insured