



FUTURE GENERALI INDIA

Insurance Company Limited

FUTURE TRAVEL SURAKSHA CLAIM FORM

Please contact our 24 hour Helpline (ISOS Assistance Centre) on Phone No _____ & Fax No _____
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 Medical Expense <input type="checkbox"/> Repatriation of Remains <input type="checkbox"/> Medical Transportation <input type="checkbox"/> Emergency Medical Evacuation <input type="checkbox"/> Balance Period of Policy <input type="checkbox"/> Daily Allowance in case of Hospitalization <input type="checkbox"/> Emergency Sickness Dental Relief <input type="checkbox"/>	B. Travel Inconvenience Hijack Distress Allowance <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"/> Baggage Delay <input type="checkbox"/> Compassionate Visit <input type="checkbox"/> Financial Emergency Assistance <input type="checkbox"/>
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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: _____ **Signature of the claimant/ Insured**
Date: _____