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## FUTURE TRAVEL SURAKSHA CLAIM FORM



1. Policy Number 2. Policy Plan Type 4. Policy End date 5. Name of the Insured Person (in whose name the policy is issued) 6. (a)Name of the claims 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:	2. This is a One Call Claim separate Claim Form	es not imply acce a Form, except fo ions completely.	Europ Assistance) on Phone on 24 hour helpline in respect eptance of the liability or a waiver Accidental Death & Disability, Eln case of insufficient space attard slips to your claim.	of Medical & Accident of terms, conditions & e Burglary, Hijack Distress	claims shall in	validate your claim.	provide a
3. Policy Start 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) 6. (a)Name of the claimant Person (in respect of whom the claim is made) 6. (a)Name of the claimant Person (in respect of whom the claim is made) 6. (c) Present completed age 6. (d) Occupation 6. (e) Contact Number  7. Trip Details:  Date of Departure:	1 Policy Number			2 Policy Plan Type			
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 (d) Occupation (e) Residential Address  7. Trip Details:  Date of Departure:							
(b) Relationship to the Insured (c) Present completed age (d) Occupation (e) Residential Address  7. Trip Details: Date of Departure: Date of Departure: Date of Departure: Date of Departure: Date of Minds of Departure: Date of Minds of Departure: Date of Arrival: Date of Minds of Departure: Date of Arrival: Date of Minds of Departure: Date of Arrival: Date of Of Dolicy ALLOWANCE DURING HOSPITALIZATION & COMPASSIONATE VISIT  Date of Onset of illness/ disease/ailment: Date of Onset of illness/ disease/ailment: Date of Onset of Illness/ disease/ailment: Date of Onset of Daily Hospital where treatment was given: Name of the Hospital where treatment was given: Date of Onset of illness/ disease/ailment: Date of Onset of illness/ disease/ailment: Date of Onset of illness/ disease/ailment: Date of Onset of Daily Hospital where treatment was given: Name of the Hospital where treatment was given: Date of Onset of illness/ disease/ailment: Date of Onset of illness/ disease/ailment: Date of Onset of Daily Hospital where treatment was given: Name of the Hospital where treatment was given: Date of Onset of illness/ disease/ailment: Date of Onset of illness/ disease/ailment: Date of Onset of Daily Hospitalization Cash Allowance: YES / NO In case of Compassionate visit: Treatment Date: From		rean (in whose n	ame the policy is issued)	4. Folicy End date			
(b) Relationship to the Insured (d) Occupation (e) Residential Address  7. Trip Details: Date of Departure: / Flight No: From To To Date of Arrivat: / Flight No: From To		7.50					
(e) Residential Address  7. Trip Details: Date of Departure:	. ,	, ,	oct of whom the dam to made,	(c) Present completed	age		
(e) Residential Address  7. Trip Details: Date of Departure:		n c c					
7. Trip Details: Date of Departure:				(c) contact rumber			
Date of Arwai:	(e) Residential Address						
Date of Departure:							
Date of Departure:	7 Trin Details						
Respect of following section (please tick against the claim type)	Date of Departure:/	/	Flight No:	From	То		
A. Medical Care  Medical Expense Repatriation of Remains Medical Transportation Balance Period of Policy Daily Allowance in case of Hospitalization 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: Date of Onset of illness/ disease/ailment: Date of Onset of illness/ disease/ailment: Date of Medical Evacuation: Date of Medical Evacuation: Preatment Date: Reason of Medical Evacuation: Place where Patient is evacuated: Date of Compassionate visit: Treatment Details:  Reason of Medical Evacuation: Place where Patient is evacuated: Date of Compassionate visit: Treating Doctor's opinion for the necessity of an attendant: Documents Required: Discharge Summary, Investigation Reports, Doctors Certificate stating tooth/feeth treated, Doctors Certificate stating the necessity of an attendant (compassionate visit), Medicine prescriptions & Bills, Bills and Receigespenses incurred:	Date of Arrival:/	_/	Flight No:	From	To		
A. Medical Care  Medical Expense Repatriation of Remains Medical Transportation Emergency Medical Evacuation Balance Period of Policy Daily Allowance in case of Hospitalization 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: Details of illness/ disease/ailment is pre-existing/ aggravated due to pre-existing condition, mention the details:  Treatment Date: From/ To/ Treatment Date: From/ To/ Treatment Details:  Reason of Medical Evacuation: Place where Patient is evacuated: C. Personal Care Baggage Loss Baggage Los	Passport No:						
Name of Treating Doctor: Details of illness/ disease/ailment: Date of Onset of illness/ disease/ailment: Date of Onset 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:  If reatment Date:  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:  It reating 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 Medical Evacuation, Doctor's Certificate confirming the necessity of an attendant (compassionate visit), Medicine prescriptions & Bills, Bills and Receiptexpenses incurred:	Emergency Medical Evacua Balance Period of Policy		Trip Curtailment Missed Connection	n			
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:  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 Medical Evacuation, Doctor's Certificate confirming the necessity of an attendant (compassionate visit), Medicine prescriptions & Bills, Bills and Receip expenses incurred:	MEDICAL EXPENSE  Name of the Hospital where	al Relief  COVERAGE, ALLOW  re treatment was	EMERGENCY SICKNESS D VANCE DURING HOSPITAL given:	IZATION & COMPAS	SIONATE VIS	EDICAL EVACUATION, SIT	DAILY
Reason of Medical Evacuation:  Place where Patient is evacuated:  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 Medical Evacuation, Doctor's Certificate confirming the necessity of an attendant (compassionate visit), Medicine prescriptions & Bills, Bills and Receip expenses incurred:	MEDICAL EXPENSE  Name of the Hospital where Address of the Hospital who Name of Treating Doctor:	COVERAGE, ALLOW re treatment was here treatment was	EMERGENCY SICKNESS D VANCE DURING HOSPITAL given:	IZATION & COMPAS	SIONATE VIS	EDICAL EVACUATION,	DAILY
Place where Patient is evacuated: Date of Medical Evacuation:	MEDICAL EXPENSE  Name of the Hospital where Address of the Hospital who Name of Treating Doctor:Details of illness/ disease/a	COVERAGE, ALLOW re treatment was here treatment was here treatment: sease/ ailment:	EMERGENCY SICKNESS D VANCE DURING HOSPITAL given: as given:	IZATION & COMPAS	SIONATE VIS	EDICAL EVACUATION,	DAILY
Treating Doctor's opinion for the necessity of an attendant:	MEDICAL EXPENSE  Name of the Hospital where Address of the Hospital who Name of Treating Doctor: _Details of illness/ disease/a  Date of Onset of illness/ disf the illness/disease/ailmer  Treatment Date: From _/_	coverage, ALLOW re treatment was here treatment was here treatment was here treatment in the sease/ ailment:	EMERGENCY SICKNESS DIVANCE DURING HOSPITAL given: as given: /// aggravated due to pre-existing	IZATION & COMPAS	SIONATE VIS	EDICAL EVACUATION,	DAILY
Item No Details of Expenses Incurred Amount	MEDICAL EXPENSE  Name of the Hospital where Address of the Hospital where Name of Treating Doctor:	coverage, ALLOW re treatment was bere treatment was bere treatment: sease/ ailment: nt is pre-existing/	EMERGENCY SICKNESS D VANCE DURING HOSPITAL given:	condition, mention the de	etails:	IIT	DAILY
	MEDICAL EXPENSE  Name of the Hospital where Address of illness/ disease/allness/ disease/ allness/ dis	coverage, ALLOW re treatment was bere treatment was bere treatment was bere treatment.  sease/ ailment: nt is pre-existing/  / To	EMERGENCY SICKNESS D VANCE DURING HOSPITAL given:	condition, mention the de	etails:	octors Certificate stating the	ne reason
	MEDICAL EXPENSE  Name of the Hospital where Address of the Hospital where Address of the Hospital where Name of Treating Doctor:	coverage, ALLOW  re treatment was here treatment was here treatment:  sease/ ailment:  nt is pre-existing/  / To  ation: cuated: cization Cash Allo  visit: for the necessity of charge Summary or's Certificate co	emergency sickness of the property of an attendant:  In Investigation Reports, Doctors of infirming the necessity of an attendant attendant and the property of the property o	condition, mention the de	etails:	octors Certificate stating the escriptions & Bills, Bills and	ne reason
	MEDICAL EXPENSE  Name of the Hospital where Address of the Hospital where Address of the Hospital where Address of the Hospital who Name of Treating Doctor:	coverage, ALLOW  re treatment was here treatment was here treatment:  sease/ ailment:  nt is pre-existing/  / To  ation: cuated: cization Cash Allo  visit: for the necessity of charge Summary or's Certificate co	emergency sickness of the property of an attendant:  In Investigation Reports, Doctors of infirming the necessity of an attendant attendant and the property of the property o	condition, mention the de	etails:	octors Certificate stating the escriptions & Bills, Bills and	ne reasor

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REPATRIATION OF REMAINS & MEDICAL TRANSPORTATION						
Cause of Death	n/ Medical Transportation:					
Documents Red	quired: Death Certificate, Doctors Certificate for cause of death/ Medical Details of Expenses Incurred	Transportation, Bills & Receipts of expenses incurred:  Amount				
	TRIP DELAY, TRIP CANCELLATION, TRIP CURTAIN	MENT & MISSED CONNECTION				
Claim Type: Tri	p Delay / Trip Cancellation / Trip Curtailment / Missed Connection					
Date & Time of	rrier:atam/pm. Date & Time of schedu departure for connecting flight:/atam/pm on/ Incident due to which Trip was Delayed/Cancelled/Curtailed/Missed					
Name of the far	Incident: _/_/ at am/pm. Person affected of incident: Claim mily member affected: Relationship cted person:	nant/ Family Member of affected person with claimant:				
illness), Death	quired: Carrier Authority Report stating the reason for delay (if carrier was Certificate (if family member is dead), Bills & Receipts for expenses incur	red:				
Item No	Details of Expenses Incurred	Amount				
	LOSS OF PASSPORT, BAGGAGE LOSS & BAGGAGE	DELAY (CHECKED IN BAGGAGE)				
Name of the Ca	arrier:					
In case of bagg	age loss/ loss of passport: paggage/ passport was lost://Place where baggage/pass	port was lost:				
In case of bagg Date & Time of Date & Time of	age delay: Arrival:// at am/pm. Airport of Disembarkation Retrieval of Baggage:// at am/pm	:				
	quired: Police report made within 24 hrs of loss of passport, Property irret baggage, Bills & Receipts as a proof of ownership of for items lost with					
Item No	Details of Expenses Incurred	Amount				
FINANCIAL EMERGENCY ASSISTANCE						
Date on which f Details of reaso	Date on which fund was lost: / / Details of reason for loss of fund:					
Documents Por	quired: Police report made within 24 hrs of loss.					
I/ We hereby have made a	DECLARATION to the best of my/ our knowledge and belief, warrant the truth of lready or if I/ We make in any of my/ our further statements in suppress or conceal any material fact, the policy shall be void	n respect of the said incident or any false or fraudulent				
Place: Date:		Signature of the claimant/ Insured				

Future Generali India Insurance Company Limited

Corporate & Registered Office - 001, Trade Plaza, 414, Veer Savarkar Marg, Prabhadevi, Mumbai 400 025

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