

V Toll Free Phone: 1800-103-8889

Toll Free Fax: 1800-103-9998

ACCIDENT SURAKSHA CLAIM FORM

THE ISSUE OF THIS FORM IS NOT TO BE TAKEN AS AN ADMISSION OF LIABILITY

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*In case nominee has been declared at the time of proposal, then no change will be accepted at the time of claim. Legal Heir Certificate is mandatory if nominee details are not available in policy.



NE FUTURE	V Toll Free Phone: 1800-103-888
FUTURE GENERALI	Toll Free Fax: 1800-103-9998
TAL INSURANCE SOLUTIONS	☑ e-mail id: fgh@futuregenerali.in

9.	In case of Confinement/ Away from work: Please mention	the	period of confinement	
	(This should be the actual days when away from work on i	Medi	cal Advice)	
	Total Confinement Period: From	(I	DD/MM/YYYY) To	(DD/MM/YYYY)
10.	Have the Police been informed about the accident? ☐ YES	;	□ NO	
	If yes, please give following details and submit the FIR an	d Me	dico Legal Certificate (MLC) alo	ng with claim documents.
	MLC No:		FIR No:	
	Name & Address of the Police Station:			
11.	Please provide following details of CASUALTY DOCTOR (Do			nt after the accident)
	Hospital / Clinic Name:			
	Hospital / Clinic Address:			
	Contact No:			
	DETAIL OF OTHER HEALTH / PERSONAL ACCIDENT POLICE	CIES	AND CLAIMS	
12.	Are you insured under any other Policy? ☐ YES ☐ NO)		
	(If yes, Please provide following details)			
	Name of the Insurance Company:			
	Policy No:			
	Period of Insurance:			
	Policy Issuing Office:			
	Have you made any Claims in Past?			
	(If yes, please provide details including)			
	Nature of Accident:			
	Claim Amount:			
	Claim Amount.			
	DECLARATIONS			
	Wehere /our belief and knowledge. In event above information or icy will be forfeited. I/We also agree to provide additional in	any	part thereof is found incorrect,	
Da	ite:			
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			Signature of	Insured/ Nominee



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e-mail id: fgh@futuregenerali.in

ATTENDING PHYSICIAN'S STATEMENT

(To be filled completely and signed by Attending Physician only. Incomplete Statement will lead to closure of claim) 1. Name of Injured Person: 2. Age of Injured Person: _____ (DD / MM / YY) Time of Accident: ____ Date of Accident: __ History and Alleged Cause of Injury: Nature of the Accident, Clinical Details of Injuries Sustained: Provisional Diagnosis: _ Does the Cause of Accident as stated by the Claimant tally as per your opinion? □ YES 7. □ YES Are the injuries solely due to the accident? If yes, please provide the injury certificate: _ Please specify exact anatomical site and extent of injury: _____ 10. Do the injuries appear fresh or old: ☐ FRESH ☐ OLD 11. Please confirm probable duration since when the injury was sustained: _____ 12. Was the Injured Person suffering from any disease or injury which may have contributed to the accident or likely to aggravate his condition? □ YES 13. Was the claimant hospitalized? ☐ YES If yes, then please provide period of hospitalization: From: To 14. What treatment/ procedure/ operations were performed? _ 15. Was he/she under the influence of intoxicants or drugs at the time of accident? □ YES 16. Are you his Family Doctor? □ YES If you have treated him for any previous illness or injury, please provide details



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MLC	No.	FID No.
	No:	FIR No:
Name	e & Address of the Police Station:	
Pleas	se specify nature of Disability:	
In ca	ase of Permanent Partial Disablement: Please mention Disa	bility Percentage
Perce	entage: (%)	(In word
How	long was or will the claimant be totally disabled?	n: To
tor's M	Name:	Signature:
ress a	and Contact No:	
e:	Registration Number:	
	Document List (Any One of the Following) 1. Photocopy of cheque with printed name of Proposer	Required Information on the Document Submitted 1. Name of Proposer / Employee / Nominee (in case of death)
	Please attach any of the following documents carrying the required if the beneficiary is employee or individual)	nformation (In case of Group Personal Accident policy, NEFT is to be provided o
	Document List (Any One of the Following)	Required Information on the Document Submitted
	 Photocopy of cheque with printed name of Proposer Employee / Nominee (in case of death) 	
	2. Bank Passbook	Bank Account Number Bank Account Type
	3. Bank Statement	4. IFSC Code
	4. Duly filled NEFT form authorized by the bank	5. Bank Name & Branch name
	I hereby declare that in case of a Group Personal Assidant Policy th	
F i: I r u c	Policy. I hereby declare that the particulars given by me are correct ar provided bank account as per document submitted by me. I herewith is wrongly credited to any other account for reasons of incomplete or India Insurance Company Ltd ("Company") or any of its directors, remittance of any dues to the provided bank account shall be considundertake to advise any change in the particulars of my bank account due, through NEFT. Name of Employee / Proposer:	e claim amount shall be paid as per the beneficiary defined in the Group d complete and request you to remit any amount due to me, if any to the further declare that if any transaction is delayed or not effected at all or incorrect information as provided by me, I shall not hold Future Generali employees or agents responsible for the same. I also declare that the lered as full and valid discharge of its obligations by the company. I also to facilitate updation of records for the purpose of credit of any amount
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