GENERALI Central INSURANCE

Toll Free Phone: 1800-103-8889
Toll Free Fax: 1800-103-9998
E-mail ID: GCI.Health@generalicentral.com

HEALTH INSURANCE CLAIM FORM

ALL FIELDS IN THIS FORM ARE MANDATORY (Data will be kept confidential)

Claim Number (If Available):	

POLICY / INSURED DETAILS

Policy No : _____ Health Card No. of Patient _____

Policy Start Date _____ Policy End Date _____ Date of Joining the Policy _____

Corporate Name : _____ (Only for Group Policies) Employee ID _____

PERSONAL DETAILS OF EMPLOYEE/PROPOSER

1	Name of the Employee / Individual:
2	E-Mail address of the Employee/Individual:
3	Mobile Number :
4	Permanent Account Number (PAN): Aadhar Card No :

CLAIMANT / PATIENT DETAILS

1	Name of the Patient:	
2	Relationship with the Employee / Proposer	◯ Self ◯ Spouse ◯ Child ◯ Parent ◯ Others _____
3	Date of Birth of Claimant:	Age _____ Years Gender ◯ Male ◯ Female ◯ Other
4	Residential Address	

CLAIM DETAILS

Total Claimed Amount:							

Claimed Amount in Words: Rupees _____

1. Diagnosis _____
2. Admission Date: _____ Discharge Date : _____
3. Name of Treating Doctor: _____
4. Mobile No. of Treating Doctor: _____
5. Name of Family Physician: _____
6. Mobile No. of Family Physician: _____
7. Details of other existing Health Policies: _____
8. Ongoing Medication : _____

Enclosure Check List :

1. Original discharge summary containing all relevant details.
2. All original bills and their pre-numbered receipts duly signed with a revenue stamp.
3. Copies of all reports & prescriptions.
4. First prescription / consultation letter from your Doctor.
5. Copy of proposer/employee photo id & address proof.
6. NEFT Form with photocopy of cancelled cheque with printed name of proposer / employee.

CONSENT REQUIREMENT FOR ACCESS TO TREATMENT PAPERS / INDOOR CASE SHEETS / MEDICAL RECORDS / INVESTIGATOR VISIT

I hereby authorize Generali Central Insurance Company Limited or any agency / individual authorized by them to obtain copies or review in person all my medical records including but not limited to admission notes, treatment sheets, indoor case papers, investigation reports, prescriptions and all other documents present in the hospital case file. Details related to my past hospitalizations in your hospital can also be provided / shown to Generali Central Insurance Company Limited or its authorized representatives. I agree that all information provided above by me in the claim documents is true and that if I have provided any false or untrue information, my right to claim the reimbursement of expenses shall be absolutely forfeited.

Name of Patient / Relative: _____

Relationship with Patient: _____

Signature of Patient / Relative: _____

Date: DD / MM / YYYY

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Please attach this form in Original to the hospital bill and other claim documents. Separate claim form required for each claim. PLEASE ENCLOSE A PHOTOCOPY OF THE HEALTH ID CARD.

AUTHORIZATION FOR TRANSFER OF CLAIM AMOUNT BY NATIONAL ELECTRONIC FUND TRANSFER

Name as per Bank Account														
Bank Name														
Branch Name & Address														
Branch MICR Code														
Branch IFSC Code for NEFT														
(Please attach a photocopy of a cheque or a blank cheque of your bank duly cancelled for ensuring accuracy of the bank name, branch name, account number & name of account holder printed)														
Account Type (Please Tick)	Saving			Current			Cash / Credit							
Account No. (as appearing in Cheque Book)														
HR Authorization & Stamp (Mandatory for Group Policies in case cheque or passbook copy not available)						Bank Authorization & Stamp (Mandatory for Retail Policies in case cheque or passbook copy not available)								

I hereby declare that the particulars given above are correct and complete and request you to remit any amount due to me, if any to the aforesaid bank account. I herewith further declare that if any transaction is delayed or not effected at all or is wrongly credited to any other account for reasons of incomplete or incorrect information as provided above, I shall not hold Generali Central Insurance Company Limited ("Company") or any of its directors, employees or agents responsible for the same. I also declare that the remittance of any dues to the aforesaid bank account shall be considered as full and valid discharge of its obligations by the company. I also undertake to advise any change in the particulars of my bank account to facilitate updation of records for the purpose of credit of any amount due, through NEFT.

Name of Employee / Proposer: _____ Signature of Employee / Proposer: _____

Policy No. _____ Claimant Name: _____ Date: _____

FEEDBACK AND SUGGESTIONS

We thank you for choosing Generali Central Insurance Company Limited as your Insurance provider. We always strive to ensure that our service levels exceed our customer's expectations. In the spirit of this endeavor, we will greatly appreciate your valuable inputs and feedback. Kindly provide your feedback on your experience with Generali Central Insurance Company Limited and any suggestions for improving our services. We value your time and promise to evaluate your suggestions for improvement of our service.

