CLAIM FORM

Please contact our 24 hour Helpline Number +91 22 67347841 (with call back facility anywhere in the world) OR You may use Country specific numbers as mentioned below in – ''HOW TO REACH US''. Failure to intimate your claim within 24 hours to our Assistance Company shall invalidate your claim.

Note:-
Issuance of the form does not imply acceptance of the liability or a waiver of terms, conditions & exclusions of policy.
Please attach all Originals bills, receipts, credit card slips or bank statement to your claim. (Mandatory)

1. Policy Number:	2. Passport No:
3. Policy Start Date:	4. Policy End date:
Please Indicate any other insurance coverage (In India/ overseas):	
Policy Number/ s:	
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) E-mail ID/s:
(d) Contact Numbers (INDIA):	(e) Contact Numbers (Overseas):
(e) Residential Address (INDIA):	

Trip Details

Date of Departure: DD / MM / YYYY	Flight No:	From:	To:
Date of Arrival: DD / MM / YYYY	Flight No:	From:	To:

Claim in Respect of following section (please tick against the applicable claim type)

A. Medical Care		**C. Personal Care**	
Medical Expense	☐	Baggage Loss	☐
Repatriation of Remains	☐	Baggage Delay	☐
Emergency Medical Evacuation	☐	Compassionate Visit	☐
Daily Allowance in case of Hospitalization	☐	Financial Emergency	☐
Emergency Sickness Dental Relief	☐	**D. Personal Accident**	
Balance Period of Policy	☐	Accidental Death	☐
B. Travel Inconvenience		Permanent Total Disability	☐
Hijack Distress	☐	Accidental Death (Common Carrier)	☐
Allowance Trip Delay	☐	Accidental Death (Air Travel Only)	☐
Trip Cancellation	☐	**E. Special Care**	
Trip Curtailment	☐	Golfers Hole in one Celebration	☐
Missed Connection	☐	Burglary (Home Contents)	☐
Loss of Passport	☐	Child Escort	☐
-		**F. Legal Liability**	
-		Personal Liability	☐

Medical Expense Coverage, Emergency Dental Relief, Emergency Medical Evacuation

Name of the Hospital: _____

Address of the Hospital: _____

Name of Treating Doctor and Contact details: _____

Details of illness & Treatment: _____

Date of First Symptom ____/____/____ please confirm if the illness was also treated in past (Pre-Existing): ☐ Yes ☐ No

Treatment / Hospitalization dates for any illness / disease in past: From ____/____/____ to ____/____/____

Treatment or surgery details of any past illness/ailment: _____

Name of medicines you are routinely taking: _____

Past History Of Any Chronic Illness With Duration					
Disease / Ailment					**Duration (Specify Years / Months / Days)**
Hypertension	Yes		No		
Hyperlipidemia	Yes		No		
Cancer	Yes		No		
Osteoarthritis	Yes		No		
Diabetes	Yes		No		
Cardiovascular Diseases	Yes		No		
Asthma / COPD / Bronchitis	Yes		No		
Congenital Internal / External	Yes		No		
Any HIV or STD/Related Ailments	Yes		No		
Alcohol or Drug Abuse	Yes		No		
Any Surgery / Hospitalization	Yes		No		
Any Other Disease / Disability	Yes		No		

Name of Family Physician (INDIA): _____

Email ID and contact details of Family Physician (INDIA): _____

If, Claiming for Medical Evacuation / Compassionate visit then specify reasons for Medical Evacuation) _____

_____

Evacuation Request Place From: _____ | Evacuation Request Place To: _____

Date of Medical Evacuation required: _____

(PLEASE ATTACH TREATING DOCTOR'S CERTIFICATE FOR THE NECESSITY OF AN ATTENDANT/ EVACUATION).

Repatriation of Mortal Remains

Cause of Death/ Medical Transportation: _____ | Place of Death: _____

Medical Transportation from _____ to _____

Date of Death / Medical Transportation: ____/____/____

Item no	**Details of expenses incurred – under medical expenses**	**Amount**
TOTAL CLAIMED AMOUNT **Kindly specify this total claimed amount.*		

Financial Emergency Assistance

Date on which fund was lost: _____ | Details of incident of loss of fund i.e. how, when, where _____

_____

Local contact Person (INDIA) who can provide payment security _____

Contact Number/s: _____

Name of the Police Station _____

Police Information (FIR) No _____

Loss of Passport, Loss of Baggage; Delay In Checked In Baggage, Trip Delay / Curtailment

Date & Time of actual arrival: _____at _____AM/PM | Date & Time of scheduled arrival: _____at _____AM/PM

Date & Time of Retrieval of Baggage: _____at _____AM/PM

Total Hours of Delay: _____| Details of Incident i.e. how, when, where: _____

_____

Date on which baggage/passport was lost: _____| Place where baggage/passport was lost: _____

Item no	Details of expenses incurred – under travel inconvenience	Amount
TOTAL CLAIMED AMOUNT **Kindly specify this total claimed amount.*		

Personal Accident Death / Disability Insurance

Claiming for Personal Accident resulting into **DEATH** ☐ / **DISABILITY** ☐ (exact details of Disability): _____

Date of Accident:_____| Place of Accident: _____| Claimed Amount: _____

Details & Circumstances of Accident i.e. how, when, where:_____

_____

Was the injured person under the influence of alcohol / drugs / medicines at the time of accident: ☐ **YES** / ☐ **NO** _____

Name of the Police Station informed about accident _____Police Information (FIR) No.: _____

Name & Address of Hospital: _____

Name & Address of Casualty Doctor: _____

Name & address of Insured's Regular physician in India: _____

Nominee Name, Address & Contact Details: _____

(PLEASE ATTACH ATTENDING PHYSICIAN'S STATEM ENT/ CIVIL SURGEON CERTIFICATE AS PER STANDARD FORM AT)

Authorization for Transfer of Claim Amount by National Electronic Fund Transfer

Please provide below mentioned details of **INSURED'S INDIAN BANK ACCOUNT** for NEFT payment.	
Bank Name:	
Branch Name & Address:	Branch Phone No.:
Name of Proposer (As per Bank A/c):	Relation with Insured:
Account No. (as appearing in Cheque Book):	
Branch IFSC Code for NEFT:	Branch MICR Code:
Account Type: Savings ☐ Current ☐ Cash / Credit ☐	
Contact numbers in India:	Alternate Email ID:
(Please attach a scanned image of a blank, duly cancelled cheque - of your bank)	

Declaration: - *I hereby declare that the particulars given above are correct and complete. If any transaction is delayed or not effected at all for reasons of incomplete or incorrect information, I shall not hold Generali Central Insurance Company Limited responsible. I also undertake to advise any change in the particulars of my account to facilitate updations of records for purpose of credit of claim amount through NEFT. I/ We hereby authorize service provider, Insurance Company & its authorized representative to collect my Medical Records, Treatment Papers, Investigation Reports etc. from Treating Doctor / Family Physician / Hospitals in India or Overseas.*

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 already made 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: _____ _____
Name of the claimant/ Insured