FUTURE GENERALI INDIA
Insurance Company Limited

ACCIDENT SURAKSHA
PERSONAL ACCIDENT POLICY

ACCIDENT SURAKSHA INSURANCE - POLICY TERMS AND CONDITIONS

This Policy is issued to **You** based on **Your** Proposal to **Us** and **Your** payment of the Premium. This **Policy** records the agreement between **Us** and sets out the terms of insurance and the obligations of each party.

1. OPERATION OF COVER

a. The cover provided by this **Policy** will only apply during the **Policy Period** stated in the **Schedule.**

b. The **Policy** does not provide coverage for any insured person unless he or she at the date of the claim is under 70 (Seventy) years of age.

c. The **policy** will not be valid unless a **Schedule** signed by one of **Our** Authorized Representatives is attached.

2. DEFINITIONS

Following words are phrases whenever they appear in italics in this policy wording have special meanings as defined below against each of them:

You, Your, Yourself	The Insured Person shown in the **Schedule.**
We, Our, Us, Insurer	Future Generali India Insurance Company Limited.
Schedule	That portion of the **Policy** which sets out **Your** personal details, the type of insurance cover in force, the period and the sum insured. Any Annexure or Endorsement to the **Schedule** shall also be a part of the **Schedule**.
Proposal	The application (Proposal) form for insurance cover submitted to **Us** along with all information which has enabled **Us** in considering whether and on what terms to offer this insurance.
Policy	The complete documents consisting of the Proposal, Policy wording, Schedule and Endorsements and attachments if any.
Occupation	Occupation of **Insured Persons** as shown in the **Schedule** or as declared to **Us** in the **Proposal**
Policy Period	The period commencing with the start date mentioned in the **Schedule** till the end date mentioned in the **Schedule.**
Accident, Accidental	A sudden, unintended and fortuitous external and visible event.
Accidental Bodily Injury	Any injury to **You** caused by an accident which occurs during the **Policy Period** but does not include any condition which is also a sickness or illness or disease or any degenerative condition provided that the injury results in any of the events specified in the table of events within 12 calendar months from the date of such injury
Doctor/Physician	A qualified medical practitioner holding a valid and subsisting license granted by the appropriate licensing authority and acting within the scope of his license.
Permanent Total Disablement	Means disablement which entirely prevents an Insured Person from attending to any Business or Occupation of any and every kind and which lasts 12 months and at the expiry of that period is beyond hope of improvement.
Permanent Partial Disablement	**Doctor** certified total and continuous loss or impairment of a body part or sensory organ specified
Temporary Total Disablement	Means disablement which temporarily and totally prevents the Insured Person from attending to the duties of his usual business or occupation and shall be payable for a maximum period of 100 weeks during such disablement from the date on which the Insured person first became disabled.
Total Sum Assured	The amount stated in the **Schedule,** which is the maximum amount we will pay for claims made by **You in one policy period** irrespective of the number of claims **You** make or the number of years that **You** have had Personal Accident policy with **Us**.
Principal Sum Insured	The highest of the sum insured mentioned for Death or Permanent Total Disablement or Permanent Partial Disablement Benefit.
Reasonable and Customary Charges	A charge incurred for medical treatment that are medically necessary to treat **Your** condition and not exceeding the usual level of charges for similar medical services in the locality where expense is incurred and excludes any charge that would not have been made if there was no insurance.
Hospital	A legally recognized establishment which holds a valid license to practice medicine and provide for the care and treatment of injured persons, with minimum of 10 beds, one or more physicians available at the premises at all times and provides 24 hour nursing service with at least one qualified and registered professional nurse present and on duty at all times.
Fingers or Toes	Whether in the singular or plural, means the digits of a hand or foot
Insured Person	Whether in singular or plural means the person(s) who come within the description of Insured Persons stated in the **Schedule**, for whom premium has been paid.
Limb	Whether in singular or plural, means an arm at or above the wrist or a leg at or above the ankle

3. WHAT WE WILL PAY FOR

Following an **Accidental Bodily Injury** to **You** which results in any of the events listed in the Table of Events, we will pay **You** or **Your** nominee such percentage stated against the event in the Table of Events of the sum insured stated in the **Schedule** provided that the **Schedule** mentions that You have opted for coverage against that event and paid premium for the same.

PRIMARY COVERS

The **Primary Cover** includes the following benefits. **We** will make payment for the benefits as specified in the **Schedule.**

A. Accidental Death

B. Permanent Total Disablement

C. Permanent Partial Disablement

D. Temporary Total Disablement

Table of Events

Event	Percentage of Sum insured
• Death	100%
• Permanent Total Disablement	100%
• Permanent Partial Disablement	As Follows
• Permanent Total Loss of sight of both eyes	100%
• Permanent Total Loss of sight of one eye and physical separation of or the loss of ability to use either one hand or one foot	100%
• An arm at the shoulder joint	75%
• An arm above the elbow joint	70%
• A hand at the wrist	50%
• An arm beneath the elbow joint	60%
• A thumb	25%
• An index finger	10%
• Any other finger	5%
• A leg above mid-thigh	75%
• A leg up to mid thigh	60%
• A leg up to beneath the knee	50%
• A leg up to mid-calf	45%
• A foot at the ankle	40%
• A large toe	5%
• Any other toe	2%
• Permanent Loss of sight of one eye	50%
• Hearing of one ear	25%
• Hearing of both ears	75%
• Sense of smell	10%
• Sense of taste	5%
• Shortening of leg by at least 5%	7%
• Temporary Total Disablement	As per the benefit plan

For any other **Permanent Partial Disablement** event not provided above. **We** shall pay an appropriate percentage of principal sum insured as decided by **Us.**

If a claim has already been settled for any of the primary covers the amount payable for the subsequent claims/s under any other primary covers shall be reduced by the amount/s already paid.

Regardless of one or more claims during the policy period, the maximum amount payable towards the Primary Cover shall be restricted to the Principal Sum Insured.

If more than one loss results from any Accident, only the one amount the largest, will be paid.

This policy shall cease for the particular Insured Person on payment of a claim for Death or Permanent Total Disablement of that Insured Person.

4. ADDITIONAL COVERS

We will make payment for the following additional benefits if the **Schedule** mentions that **You** have availed the same and paid the additional premium applicable.

(a) Child Education Support

In the event of **We** making payment for a claim for Death or Permanent Total Disablement, We will also be making payment towards the education support of **Your** child upto 21 years of age for the sum insured mentioned against this benefit per month for the maximum period as stated in the Schedule .This benefit shall be limited to the maximum as stated in the Schedule irrespective of the number of children.

(b) Life Support Benefit

In the event of **We** making payment for a claim for **Permanent Total Disablement, We** will also make payment towards **Your** life support the sum insured mentioned against this benefit per month for the number of months mentioned in the **Schedule.**

(c) Accidental Medical Expenses

In the event of valid claim under this policy for Death, **Permanent Total Disablement, Permanent Partial Disablement, Temporary Total Disablement We** will reimburse the **Reasonable and Customary charges,** subject to Deductibles if any shown in the **Policy Schedule,** towards Hospitalisation expenses incurred for medical treatment for the injury sustained, as an inpatient in a **Hospital** in India for a minimum period of 24 hours. The maximum amount payable towards this cover shall be the sum insured shown in the **Schedule** against this cover.

(d) Hospital Cash Allowance

In the event of **Us** paying a claim for **Accidental Medical Expenses,** we will also make payment of the sum mentioned in the **Schedule** for each completed day of hospitalization for a maximum period mentioned in the **Schedule.**

(e) Loan Protector

In the event of Us making a payment for Death or **Permanent Total Disablement, We** will also pay the sum mentioned in the **Schedule** against this benefit per month or the actual Loan EMI **You** are liable to pay, whichever is less for the maximum period mentioned in the **Schedule**. **We** will also make payment towards this benefit for each completed month of hospitalization in the event of **You** meeting with an **Accident** and getting hospitalized. The maximum payment during the policy period shall be the number of months mentioned in the **Schedule.**

(f) Repatriation Benefit and Funeral Expenses

In the event of **We** making payment for a claim for Accidental Death **We** will also make payment towards

I. Expenses incurred for preparing **Your** body for burial or cremation and transportation of **Your** body to **Your** city of residence provided the place of death is not less than 100 kms from **Your** normal place of residence.

II. **Your** funeral expenses.

The maximum towards a & b together shall be limited to 1 % of the Principal Sum insured subject to maximum of Rs 12500/-.

(g) Adaptation Allowance

If **You** are required to modify **Your** vehicle or make some changes in **Your** house as necessitated by a **Permanent Total Disablement** which resulted from an accident covered under this Policy, **We** shall reimburse such expenses up to a limit of 10% of the **Principal Sum Insured** subject to a maximum of Rs.50,000 provided we have paid the claim towards **Permanent Total Disablement.**

(h) Family Transportation Allowance

Following an accidental injury which results in **Death, Permanent Total or Permanent Partial Disablement** indemnifiable under this policy, if the **Insured Person** is confined in a hospital outside 100 kms of his normal place of residence, within 12 months from the date of accident, and the attending physician recommends the personal attendance of an immediate family member, we shall reimburse the expenses incurred for the immediate family member for transportation by the most direct route by a licensed common carrier to the place of confinement of the **Insured Person.** The maximum amount payable for this cover shall be limited to 10% of **the Principal Sum Insured** subject to maximum Rs.50,000/-.

5. WHAT IS NOT PAYABLE

We will not pay for any compensation, benefit or expenses in respect of Death, Injury or Disablement, Accidental Medical Expenses of the Insured person as a consequence of the following

a. Intentional self injury (including but not limited to the use or misuse of any intoxicating drugs or alcohol)

b. Accident while under the influence of alcohol or drugs.

c. Participation in an actual or attempted felony, riot, crime, misdemeanor or civil commotion

d. Any accident of which a contributing cause was **Your** actual or attempted commission of, or willful participation in, an illegal act or any violation or attempted violation of the law or **Your** resistance to arrest.

e. Whilst engaging in Aviation or Ballooning or whilst mounting into, dismounting from or traveling in any balloon or aircraft other than as passenger (fare paying or otherwise) in any duly licensed standard type of aircraft.

f. Participating in motor racing or trial run as a driver, co-driver or passenger

g. Curative treatments or interventions that **You** carry out or have carried our on **Your** body

h. Pregnancy and childbirth, miscarriage, abortion or complications arising out of any of these

i. War, invasion, acts of foreign enemies, hostilities (whether war be declared or not), civil war, commotion unrest, rebellion, revolution, insurrection, military or usurped power or confiscation or nationalization or requisition of or damage or under the order of any government or public authority

j. Nuclear energy, radiation

k. Any existing disablement prior to the inception of the policy

l. Venereal or sexually transmitted diseases, HIV (Human Immunodeficiency Virus) or HIV related illness including AIDS (Acquired Immune Deficiency Syndrome) and / or mutant derivatives or variations however caused.

m. Any medical expenses, services, supplies or treatment or hospital stay which were not recommended or approved as medically necessary by a Physician.

n. Any expense incurred which is not exclusively medical in nature

o. Expenses incurred for emergency medical evacuation

6. THINGS YOU SHOULD DO

1. If **You** meet with an accidental bodily injury that may result in a claim, then

a. **You** must immediately consult a Doctor and follow the advice and treatment that he recommends

b. **You** or someone claiming on **Your** behalf must inform **Us** in writing immediately and in any event within 15 days

c. **You** must take reasonable steps to lessen the consequences of **Your** bodily injury.

d. **You** or someone claming on **Your** behalf must promptly give **Us** the documentation an other information **We** ask for to investigate the claim or **Our** obligation to make payment for it.

e. **You** must have Yourself examined by **Our** medical advisors if **We** ask for this and as often as **We** consider this to be necessary.

f. In case of **Your** death, someone claiming on **Your** behalf must inform **Us** in writing immediately and send **Us** a copy of the Post Mortem report, FIR or any other document as required by **Us** within 15 days.

2. **We** have agreed to issue this policy based on the occupation that **You** have declared to **Us** while taking this policy. If **You** change **Your** occupation then **You** must tell Us in writing within 30 days of the change. If **You** do not do this, then this insurance will cease as far as **You** are concerned from the date that **You** changed **Your** occupation.

3. **You** should send any communication meant to **Us** in writing to **Our** address shown in the **Schedule.**

4. If **You** wish to cancel this policy **You** should give us 15 days notice in writing. **We** shall refund **You** balance premium after retaining premium as per the scale shown below:

Policy Period not exceeding	% of Annual Rate
1 month	20%
3 months	40%
6 months	70%
9 months	90%

7. THINGS WE WILL DO THINGS

a. **We** will send any communication meant to **You** to **Your** address shown in the **Schedule.**

b. **We** will make claim payment to **You** or **Your** Nominee. If there is no Nominee and **You** are incapacitated or deceased, **We** will pay **Your** heir, executor or validly appointed legal representative and any payment **We** make in this way will be a complete and final discharge of **Our** liability to make payment.

c. **We** will make all claim payments in Indian rupees within India only.

d. If **We** cancel this policy **We** will give You 15 days notice in writing. In such cases **We** shall make **You** pro rata refund of premium for the balance period.

e. If **You** renew this policy with **Us** within 7 days of expiry of the policy **We** shall give You 5% increase on the primary covers for each continuous claim free year. Maximum increase shall be 25% of the original policy sum insured. **You** will be eligible for this benefit only if the **Schedule** mentions that such benefit is included in the plan opted by **You.**

f. If **You** renew this policy continuously with **Us, You** may become eligible for Renewal Discount in the renewal premium payable as per **Our** guidelines.

g. This Policy may be renewed by mutual consent every year and in such event, the renewal premium shall be paid to Us on or before the date of expiry of the Policy or of the subsequent renewal thereof. However We shall not be bound to give notice that such renewal premium is due.

8. WHAT YOU SHOULD NOT DO

a. **You** should not make any claim knowing it to be false or fraudulent in any way.

b. **You** should also not conceal, misrepresent intentionally or otherwise any fact or circumstance that **We** consider as material to this insurance.

c. If **You** do so then the policy shall be void and all claims or payments due under it shall be lost.

9. DISPUTE RESOLUTION

a. Any dispute regarding the claim amount, liability otherwise being admitted, are to be referred to arbitration under the Arbitration & Conciliation Act 1996. The law of the arbitration shall be Indian law and the seat of the arbitration and venue for all the hearings shall be within India.

b. If these arbitration provisions are held to be invalid, then all such disputes or differences shall be referred to the exclusive jurisdiction of the Indian courts.

10. COMPLIANCE WITH POLICY PROVISIONS

Failure by **You** to comply with any of the provisions in this **Policy** may invalidate all claims hereunder.

11. USE OF MASULINE PRONOUN

A masculine personal pronoun as used in this **Policy** includes the feminine, wherever the context requires.

12. TERRITORIAL LIMITS AND LAW

We cover **Accidental Bodily injury** sustained by **You** during the **Policy Period** anywhere in the World (subject to the travel and other restrictions that the Indian Government may impose), but **We** will make payment within India and in Indian Rupees. The construction, interpretation and meaning of the provisions of this **Policy** shall be determined in accordance with Indian Law

Grievance Redressal Procedures

Dear Customer,

At **Future Generali** we are committed to provide Exceptional "Customer-Experience" that you remember and return to fondly. We encourage you to read your policy & schedule carefully. We want to make sure the plan is working for you and welcome your feedback.

What Constitutes a Grievance?

A "Grievance/Complaint" is defined as any communication that expresses dissatisfaction about an action or lack of action, about the standard service/deficiency of service from Future Generali or its intermediary or asks for remedial action.

If you have a complaint or grievance you may reach us through the following avenues:

	**24X7 Help-lines**	MTNL/BSNL :1800-220-233		**Email**	**care@futuregenerali.in**
		Others :1860-500-3333		**Website**	**www.futuregenerali.in**
	**Customer Service Cell**	**Future Generali India Insurance Company Ltd.** Corporate & Registered Office:- 001, Delta Plaza, 414, Veer Savarkar Marg, Prabhadevi, Mumbai - 400 025			

While sending in your complain in writing, please use the complaint form, annexed with your policy. Kindly quote your policy number in all communication with us. This will help us to deal with the matter faster.

- We will acknowledge receipt of your concern within 3 - business days.
- Within 2 - weeks of receiving your grievance, we shall revert to you the final resolution.
- We shall regard the complaint as closed if we do not receive a reply within 8 weeks from the date of receipt of response.

While we constantly endeavor to promptly register, acknowledge & resolve your grievance, if you feel that you are experiencing difficulty in registering your complaint, you may register your complaint through the IRDA (**Insurance Regulatory and Development Authority**).
CALL CENTER: TOLL FREE NUMBER (155255).

INSURANCE OMBUDSMAN
If you are still not satisfied with the resolution to the complaint as provided by our Grievance Redressal Officer, you may approach the Insurance Ombudsman for a review. The Insurance Ombudsman is an organization that addresses grievances that are not settled to your satisfaction. You may reach the nearest insurance ombudsman office. The list of Insurance Ombudsmen offices is as mentioned below.

Office of the Ombudsman	Contact Details	Areas of Jurisdiction
AHMEDABAD	Insurance Ombudsman Office of the Insurance Ombudsman 2nd Floor, Ambica House, Nr. C.U.Shah College, 5, Navyug Colony, Ashram Road, **AHMEDABAD - 380 014** Tel: 079- 27546840 Fax: 079-27546142 E-mail: ins.omb@rediffmail.com	Gujarat, UT of Dadra & Nagar Haveli, Daman and Diu
BHOPAL	Insurance Ombudsman Office of the Insurance Ombudsman Janak Vihar Complex, 2nd Floor, 6, Malviya Nagar, Opp. Airtel, Near New Market, **BHOPAL - 462 023** Tel: 0755-2569201 Fax: 0755-2769203 E-mail: bimalokpalbhopal@airtelmail.in	Madhya Pradesh & Chhattisgarh
BHUBANESHWAR	Insurance Ombudsman Office of the Insurance Ombudsman 62, Forest Park, **BHUBANESHWAR - 751 009** Tel: 0674-2596455 Fax: 0674-2596429 E-mail: ioobbsr@dataone.in	Orissa
CHANDIGARH	Insurance Ombudsman Office of the Insurance Ombudsman S.C.O. No.101, 102 & 103, 2nd Floor, Batra Building, Sector 17-D, **CHANDIGARH - 160 017** Tel: 0172-2706468 Fax: 0172-2708274 E-mail: ombchd@yahoo.co.in	Punjab, Haryana, Himachal Pradesh, Jammu & Kashmir, UT of Chandigarh
CHENNAI	Insurance Ombudsman Office of the Insurance Ombudsman Fatima Akhtar Court, 4th Floor, 453 (old 312) Anna Salai, Teynampet, **CHENNAI - 600 018** Tel:044-24333668 /5284 Fax: 044-24333664 E-mail: insombud@md4.vsnl.net.in	Tamilnadu, UT- Pondicherry Town and Karaikal (which are part of UT of Pondicherry)
NEW DELHI	Insurance Ombudsman Office of the Insurance Ombudsman 2/2 A, Universal Insurance Bldg. Asaf Ali Road, **NEW DELHI - 110 002** Tel: 011-23239633 Fax: 011-23230858 E-mail: iobdelraj@rediffmail.com	Delhi & Rajashthan
GUWAHATI	Insurance Ombudsman Office of the Insurance Ombudsman Jeevan Nivesh, 5th floor Nr. Panbazar Overbridge, S.S. Road, **GUWAHATI - 781 001** Tel:0361-2132204/5 Fax: 0361-2732937 E-mail: ombudsmanghy@rediffmail.com	Assam, Meghalaya, Manipur, Mizoram, Arunachal Pradesh, Nagaland and Tripura
HYDERABAD	Insurance Ombudsman Office of the Insurance Ombudsman 6-2-46 , 1st Floor, Moin Court Lane, Opp. Saleem Function Palace, A.C.Guards, Lakdi-Ka-Pool, **HYDERABAD - 500 004** Tel: 040-65504123 Fax: 040-23376599 E-mail: insombudhyd@gmail.com	Andhra Pradesh, Karnataka and UT of Yanam - a part of UT of Pondicherry
ERNAKULAM	Insurance Ombudsman Office of the Insurance Ombudsman 2nd Floor, CC 27/2603, Pulinat Building, Opp. Cochin Shipyard, M.G. Road, **ERNAKULAM - 682 015** Tel: 0484-2358759 Fax: 0484-2359336 E-mail: iokochi@asianetindia.com	Kerala, UT of (a) Lakshadweep, (b) Mahe - a part of UT of Pondicherry
KOLKATA	Insurance Ombudsman Office of the Insurance Ombudsman North British Bldg. 29, N.S. Road, 4th Floor, **KOLKATA - 700 001** Tel: 033-22134866 Fax: 033-22134868 E-mail : iombkol@vsnl.net	West Bengal, Bihar, Jharkhand and UT of Andeman & Nicobar Islands, Sikkim
LUCKNOW	Insurance Ombudsman Office of the Insurance Ombudsman Jeevan Bhawan, Phase 2, 6th Floor, Nawal Kishore Road, Hazratganj, **LUCKNOW - 226 001** Tel: 0522 -2231331 Fax: 0522-2231310 E-mail: insombudsman@rediffmail.com	Uttar Pradesh and Uttaranchal
MUMBAI	Insurance Ombudsman Office of the Insurance Ombudsman Jeevan Seva Annexe, 3rd Floor, S.V.Road, Santacruz (W), **MUMBAI - 400 054** Tel: 022-26106928 Fax: 022-26106052 E-mail: ombudsmanmumbai@gmail.com	Maharashtra, Goa

ATTENDING PHYSICIAN'S STATEMENT

1. Details of insured Person :

Insured Name (FIRST NAME / MIDDLE NAME / LAST NAME) ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Age ☐☐☐☐☐☐☐

2. Address ☐☐☐

City ☐☐☐☐☐☐☐☐☐☐ Pin Code ☐☐☐☐☐☐☐☐☐☐☐☐

3. Nature of the Accident and Details of Injuries Sustained :______________________________________

____

4. Does the Cause of Accident as stated by the Claimant tally with the Injuries noticed by you? : Yes ☐ No ☐

5. Are the injuries solely due to the accident ? : Yes ☐ No ☐
If No pls. provide the details

6. Was the injured person suffering from any disease or injury which may have contributed to the accident or likely to aggravate his condition ? : Yes ☐ No ☐

7. Was the claimant hospitalised ? If so for what period ? : From: ☐☐☐☐☐☐ To: ☐☐☐☐☐☐

8. What treatment was given and operations performed ? :______________________________________

____

9. Give all dates of treatment : Home : From: ☐☐☐☐☐☐ To: ☐☐☐☐☐☐
Clinic/Hospital : From: ☐☐☐☐☐☐ To: ☐☐☐☐☐☐

10.Was he/she under the influence of intoxicants or drugs at the time of accident ? Yes ☐ No ☐

11. Are you his family doctor ? Yes ☐ No ☐
If you have treated him for any previous illness or injury :______________________________________
Please give details ______________________________________

12. Have other Doctors been in Attendance or Consultation? :______________________________________
If yes, Please give details ______________________________________

13.Has this accident been reported to the Police Authorities? If yes, Case No :_______ Police Stn.________

14. Is this claimant Totally Disabled from each and every occupation?__________________________________

15 (a) How long was or will the claimant be totally disabled from current occupation?
From: ☐☐☐☐☐☐ To: ☐☐☐☐☐☐
(b) How long was or will the claimant be partially disabled from current occupation?
From: ☐☐☐☐☐☐ To: ☐☐☐☐☐☐
(c) Estimated date of return to Work :______________________________________

16. What is the Prognosis? ______________________________________

Doctor's Signature :

Doctors Name :

Address and Tel. No : Date: Regn No:

Future Generali India Insurance Company Limited
Corporate & Registered Office:- 001, Delta Plaza, 414, Veer Savarkar Marg, Prabhadevi, Mumbai - 400 025
Care Lines:- MTNL/BSNL subscribers- 1800-220-233, Any other service provider- 1860-500-3333, Email: care@futuregenerali.in, Website: www.futuregenerali.in

COMPLAINT FORM

POLICY TYPE

- ☐ MOTOR
- ☐ HEALTH
- ☐ PERSONAL ACCIDENT
- ☐ TRAVEL
- ☐ HOME
- ☐ MARINE
- ☐ OTHER ____________________

POLICY DETAILS

- ☐ EXISTING SERVICE REQUEST
- ☐ POLICY NO
- ☐ CUSOMER ID
- ☐ COVER NOTE
- ☐ HEALTH CARD
- ☐ APPLICATION NO

☐☐☐☐☐☐☐☐☐☐☐☐

FIRST NAME MIDDLE NAME LAST NAME

CUSTOMER NAME ____

ADDRESS: ____

____

CITY __________ PIN CODE __________

TEL NO. __________ MOBILE NO. __________

Detailed description of the problem: ____

____

____

____

____

____

____

____

____

Customer's Signature

Date: ____________

You may submit your complaint to the Nearest Branch Office or mail it to our Customer Service Cell at:

Customer Service Cell
Future Generali India Insurance Company Ltd.
Corporate & Registered Office:- 001, Delta Plaza, 414, Veer Savarkar Marg, Prabhadevi, Mumbai - 400 025.

Care Lines: MTNL/BSNL subscribers- 1800-220-233, Any other service provider- 1860-500-3333, Email: care@futuregenerali.in Website: www.futuregenerali.in

Office Use Only:

Service / Case #

Comments: ____

____

____

____

ACCIDENT SURAKSHA CLAIM FORM

Policy No: _____ **Claim no:** _____

1. Details of Insured/ Claimant

FIRST NAME MIDDLE NAME LAST NAME

Insured Name

Claimant Name

Address

City Pin Code

Tel No. Mobile No.

Occupation Date of Birth (D D M M Y Y Y Y)

2. Accident Details

Date & Time of accident / Occurrence: Hrs.

Place & Location: _____

Description of accident /incidence:_____

_____

_____

_____

3. Details of injuries sustained

In Case of Death:
Details of the Nominee - Name & Address:_____

_____

Specify injured parts of the body:_____

Please specify nature of Disability:_____

Please mention Disability percentage in case of Permanent partial disablement:
Percentage: _____ (%) _____(In words)

4. Witnesses

Name (s):_____

Address (s): _____

_____

_____

Contact No: R: _____Off:_____Mobile:_____

5. Treatment Details

Casualty Doctor
Name : _____
Address : _____
Tel no (s) : _____

Family Doctor
Name : _____
Address : _____
Tel no (s) : _____

Hospital Details
Name : _____
Address : _____
Tel no (s) : _____

6. Confinement

Total Confinement From: ☐☐☐☐☐☐ To: ☐☐☐☐☐☐
(This should be the actual days when fully confined to bed on Medical Advise)

Partial Confinement From: ☐☐☐☐☐☐ To: ☐☐☐☐☐☐

7. Details of medical Expenses (if covered)

Date	Receipt No	Particulars	Amount

Please attach separate sheet for additional bills / receipt details

8. Policy and Claims History

A) Have you made any Claims in Past ? ☐ Yes ☐ No
B) If YES, Please give details including nature of Accident, Insurance details & Claim amount

C) Are you insured under any other Policy ? ☐ Yes ☐ No
If YES, Please give full particulars (Name of company, Policy no, Period of insurance, Policy issuing office)

Declaration

I/We agree to provide additional information to the company, if required. I/We the above mentioned, do hereby, to the best of my/our knowledge and belief, warrant the truth of the foregoing statement in every respect, and if I/We have made, or in any further declaration the company may require in respect of the said accident, shall make any false or fraudulent statement, or any suppression or concealment, the policy shall be void and all rights to recover there under in respect of past or future accident shall be forfeited.

Place :

Date : **Sign/ Thumb Impression of the insured / Nominnee**

Future Generali India Insurance Company Limited
Corporate & Registered Office:- 001, Delta Plaza, 414, Veer Savarkar Marg, Prabhadevi, Mumbai - 400 025
Care Lines:- MTNL/BSNL subscribers- 1800-220-233, Any other service provider- 1860-500-3333, Email: care@futuregenerali.in, Website: www.futuregenerali.in