FUTURE GENERALI INDIA
Insurance Company Limited

FUTURE GENERALI GROUP HEALTH - DOMICILIARY CLAIM FORM

(Issuance of this form does not imply acceptance of the liability)

Note: Every field should be answered in detail

1. Claim Number	
2. Policy Number	
3. Group Corporate Name	
4. Employee ID Number	
5. Employee Name	
6. Sum Insured Entitled	
7. Customer ID number – mentioned on health card	
8. (a) Name of the claimant person (in respect of whom the claim is made)	
(b) Relationship to the employee	
(c) Present completed age	
(d) Occupation	
(e) Residential Address	
9. Nature of disease/illness contracted or injury suffered or complete diagnosis	
10. Details of Domiciliary Hospitalization,	
(a) Date of commencement of treatment	
(b) Date of Completion of treatment	
(c) Name and address of the attending Medical Practitioner	
(d) Telephone No.	
(e) Registration No.	
(d) Contact No	

11. Schedule of expenses incurred by the claimant under domiciliary hospitalization (to be supported by original bills/receipts, cash memos, etc)

	Pharmacy/ Medicine expenses	Consultation Expenses	Investigations Expenses
Domiciliary Hospitalization Benefit			

In support of the above claim, I enclose following documents in Original (*Please indicate by tick mark*)	
1. Certificate from the attending Medical Practitioner giving reason for treatment under Domiciliary Hospitalization clause of policy	
2. Receipt from a qualified nurse who attended the patient at his/her residence duly supported by a certificate from attending Medical Practitioner	
3. Cash Memos from the Chemist(s), supported by proper prescription	
4. Receipt and Pathological test report from a Pathologist supported by the note from the attending Medical Practitioner/Surgeon demanding such Pathological test.	
5. Attending Doctor's / Consultant's / Specialist's / Anesthetist's bill and receipt and certificate regarding diagnosis and treatment.	
6. Certificate from the attending Medical Practitioner /Surgeon that the patient is fully cured.	

I hereby warrant the truth of the foregoing particulars in every respect and I agree that if I have made or shall make any false or untrue statement suppression or concealment my right to claim reimbursement of the said expenses shall be absolutely forfeited. I further declare that in respect of the above treatment no benefits are admissible under any other Medical Scheme of insurance. I consent and authorize the insurers to seek medical information from any Hospital/Medical Practitioner who has at any time attended concerning the claim.

Date: **Signature of Claimant**