FUTURE GENERALI INDIA
Life Insurance Company Limited

Policy No: _____ Claim No _____

Request For Total and Permanent Disability Claim Form

(To be filled in by person legally entitled to the claim amount)

Please answer all questions, use "not applicable" (N/A) as appropriate. Do not leave any question blank. Counter-sign where amendments/alterations are made in the replies in the form.
The filling of this form is not to be construed as an admission of liability on the part of Future Generali India Life Insurance Company Limited (" Company'') No agent has been or is authorized to admit any liability on behalf of the Company.

i) Details of the Life Assured

Full name of the Life Assured			
Correspondence Address and Contact No			
Date when last attended to work		Annual Income	
Employer Name & Address			
Bank Name & Branch			
Bank Account No (*)		Type of Account	
Employer Name & Address			

II) Lifestyle

Does the Life Assured consume Alcohol/ drugs?	☐ Yes ☐ No If Yes, i. Quantity: _____glass/peg per _____ ii. Since when _____
Does the Life Assured Smoke or otherwise use tobacco products?	☐ Yes ☐ No If Yes, i. Quantity: _____sticks/packets per _____ ii. Since when _____

Details of illness
(A)

Symptoms/Complaints	
Duration of Symptom/ Complaint	
Date of First Consultation	
Name & Address of Doctor Consulted	
Date of Event	
Event leading to main claim event and documentation of the same (FIR etc)	
Diagnosis Date	

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(B) Details of Family Doctor

Name of the Doctor	
Address	
Contact Nos.	
Email address	

(C) Name and address of the doctors who had attended / the hospitals where the Life Assured was treated during last five years:-

Name of Doctor/Hospital	**Address**	**Date of Consultation**	**Diagnosis**

IV.D. In case of TPD due to Accident

Brief details of accident (with Reg. No. of vehicles involved)			
Was the Life Assured Driving vehicle?	☐ Yes ☐ No (If Yes, please provide copy of Driving License)		
Date & Time of accident		**Place of Accident**	
Name, address & Tel No. of the hospitals .where the Life Assured was admitted after the accident			
Name, Address & Tel. Nos. of police station where accident was reported.			

V . Assignments / Reassignments

Is the policy Assigned ☐ **Yes** ☐ **No**
Is the policy Reassigned ☐ **Yes** ☐ **No**

Name and Address of the Assignee _____

VI. Details of Life Insurance Coverage by other companies

Name of Insurance Cos.	**Policy Nos. and Type.**	**Commencement Date**	**Sum Assured**	**Claim Status**

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DECLARATION & AUTHORIZATION

I _____do hereby declare that the information given on this claim request form is true and complete to the best of my knowledge and belief. I/we understand that in case any of the above information is found to be false or fabricated, the Company at its discretion may repudiate the claim amount and take necessary action against me.

I hereby authorize any doctor, physician or hospital who has attended upon or examined or treated me for any ailment or illness to divulge any knowledge or information to the Company or to any of its representative/claim investigator regarding my state of health which may have acquired whether before or after the policy was issued by the Company

I also authorize my Employer (including any previous employers) to provide information regarding the employment, leave record and medical assistance availed of by me during the tenure of such employment. I further authorize any government organizations /undertakings (including the Police or Revenue) to make available to the company or to person or agency as may be authorized by the said company, such information and records as may be needed by it to process the claim. I shall not have any objection, in case Company obtains any document pertaining to life assured or me in relation to or in respect of the abovesaid Policy or otherwise as may be required.

I agree to provide and furnish any other details and reports as and when required by the Company for processing the claim. I further declare that any communication sent to me on email is acceptable to me and shall be binding on me

Signature of Witness **Signature/Thumb Impression of Claimant / Insured**

Name of witness **Place:**

_____ _____

Address **Date:**

_____ _____

_____

VERNACULAR DECLARATION

If the Claimant signs in vernacular or affixes a thumb impression, the witness should also sign the following:

I certify that the contents of this form were explained to the Claimant in _____ (language) and he/she has affixed his/her thumb impression after fully understanding the same.

Signature _____ **Address** _____

_____

Full Name _____ _____

Contact Nos. _____

Designation _____

Note: ***This declaration must be witnessed by any one of the following Employer, Advocate, Bank Manager, Officer, Notary, Doctor, Gazette Officer, Head Master of a High School, Head Post Master or Departmental Sub-Post Master, Magistrate or President of a Village or Local Body of Branch Manager of our Company***

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List of Requirements: Please tick the documents submitted

- ☐ Original Policy Document
- ☐ Attending Physician Statement
- ☐ Indoor Case Papers of Present & Past Hospitalisations
- ☐ Discharge Summary of Present and Past Hospitalizations
- ☐ First Consultation Notes & all Follow- up Consultation Notes
- ☐ Clinical Photographs showing the injured areas - if available
- ☐ Disability Certificate by attending Physician / Institute for disabled
- ☐ Sick Leave certificate - if applicable
- ☐ Employer's written confirmation / statement - for Disability claim
- ☐ All police reports / First Information Report & Final Investigation Report - if due to accidental cause.
  - Proof of Accident – Panchnama / Inquest report - if due to accidental cause
  - Newspaper cutting / Photographs of the accident - if available.
  - Driving License, only if Life Assured was driving at the time of accident
  - Others (Please Specify)

- **All the documents submitted to us should be in Original or photocopies attested by a Gazetted Officer, SEM, Magistrate or a person of local standing, Sarpanch, Talathi, Tahsildar or Police Sub-Inspector or Branch Manager of our company.**
- **All medical reports, documents and certification shall be issued by the attending physician and who is qualified to provide such document/certification according to Indian Laws**
- **In addition to the above documents the Company reserves the rights to ask for more documents/information as may be required in consideration of the claim.**
- **Notification of claim, submission of claim forms and/or claim documents to the Company shall not be construed as an admission of liabilities of the Company. No agent is authorized to admit any liabilities on behalf of the Company, or to alter this list of documents or any claim requirements called for by the Company.**