

HEALTH INSURANCE ENDORSEMENT FORM

Terms & Conditions

- Only selected changes will be endorsed in new policy.
- Changes in proposer details, deletion of member and changes in plan/Sum Insured can be done at the time of renewal only.
- Premium may change on the basis of type of endorsement.
- If you have two policies, kindly mentioned details of both the policies.

Disclaimer:

Any discrepancy or Non-Disclosure of medical facts recorded in this document which is evident at the time of claims will be deemed to be non-disclosure/misrepresentation of material facts leading to policy cancellation and making the claim liable for rejection on the grounds of breach of policy terms and conditions and misrepresentation of facts.

Signature of proposer/customer: _____

Date: / /

Place: _____

DETAILS OF THE EXISTING INSURANCE PRODUCT/ PLANS

Existing Product	☐ ICICI Lombard Complete Health Insurance ☐ Health Booster		Existing Policy Number				
Tenure		Plan Type ☐ Individual ☐ Floater	Plan Options	☐ 1A ☐ 2A	☐ 1C ☐ 2A + 1C	☐ 1A + 1C ☐ 2A + 2C	☐ 1A + 2C ☐ 2A + 3C
Plan Details		Sum Insured	Deductible (If Applicable)				
Sub - limit (If Applicable)			Add-ons Cover (If Applicable)				

CHANGES IN PLAN / SUM INSURED

Product Name	☐ ICICI Lombard Complete Health Insurance (4128) ☐ Health Booster (4140)						
Tenure		Plan Type ☐ Individual ☐ Floater	Plan Options	☐ 1A ☐ 2A	☐ 1C ☐ 2A + 1C	☐ 1A + 1C ☐ 2A + 2C	☐ 1A + 2C ☐ 2A + 3C
Plan Details		Sum Insured	Deductible (If Applicable)				
Sub - limit (If Applicable)			Add-ons Cover (If Applicable)				

Health Declaration

☐ I hereby declare that I or anyone from the insured/s covered under the policy has/have not consulted or received any treatment from doctor or any health care provider or there has been no change(s) in health condition of the insured from the date of inception of first policy with the company till date.

OR

☐ I hereby declare that I or anyone from the insured/s covered under the policy has/have received treatment* from doctor or health care provider or the health condition of the insured has been changed from the date of inception of the first policy with the company till date.

*Please provide the documents supporting the above statement.

Note:

- Fresh waiting period as per the terms of the policy will be applicable to the enhanced limit from the effective date of such enhancement.
- Medical test is required for adults for Sum Insured option above 10 lacs, If existing sum insured is upto 10 lacs.
- Cost of Medical Check-up for policy issuance: 100% of the pre policy medical test cost will be paid by the Company. In case the health proposal is declined, medical cost will be deducted from the premium and the balance would be refunded.

Signature of the proposer/customer: _____

Place: _____

Date: / /

ADDITION/DELETION OF MEMBERS

Type (Add/Del)	Full Name (First, Middle, Last)	Gender (M/F/Third Gender)	Date of Birth (DD/MM/YY)	Relationship with Proposer	Height (feet / inch)	Weight (kgs)	Relation with the proposer (in case of change in Proposer)	PAN No.
			/ /					
			/ /					
			/ /					
			/ /					
			/ /					

Are all insured Indian nationals and Indian residents? Yes ☐ No ☐ If Not, please provide details:

Note: Medical underwriting is required for added members

Signature of the proposer/customer: _____

Place: _____

Date: / /

CHANGES IN PROPOSER DETAILS

Please fill all the particulars in CAPITAL letters only

Proposer's Name (please leave a space after each part of name)

Mr./Ms./Dr.: F I R S T M I D D L E L A S T

Date of Birth : / / Gender : Male Female Third Gender Marital Status : Single Married

[illegible]

Occupation : Salaried	Self Employed	Professional	Others	Details
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Nationality:	Indian	Others (please specify)	Residential Status:	Indian Resident	Non Resident Indian
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Educational Qualifications:	Lesser than matriculation	Matriculation	Graduate		Post-graduate	Professional Course
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Annual Income :	Less than 5 Lacs	Between 5 - 10 Lacs	Between 10 - 20 Lacs	20 Lacs and above
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GST Number: (If Applicable) _____

PAN Card No.: _____ Passport No. _____ Adhar No. _____

Signature of the proposer/customer: _____ Place: _____ Date: DD / MM / YYYY

CHANGES IN NOMINEE DETAILS

Name of Nominee : Date of Birth : D | D / M | M / Y | Y | Y | Y

[illegible]

Date of Birth of Appointee: D | D / M | M / Y | Y | Y | Y Relationship of Appointee:

Signature of the proposer/customer: Place: Date: / /

CHANGES IN CONTACT DETAILS

Correspondence Address : _____

Landmark :

City : _____ State : _____ Pin code : _____

Landline Number (with STD Code) : Mobile Number* :

E-mail address :

Signature of the proposer/customer: Place: Date: / /

CHANGES IN NAME/PLACE/DOB/DOJ

Insured No.	Full Name (First, Middle, Last)	Gender (M/F/Third Gender)	Date of Birth (DD/MM/YY)	Relationship with Proposer	New DOJ (If applicable)
1.			D D / M M / Y Y Y Y		
2.			D D / M M / Y Y Y Y		
3.			D D / M M / Y Y Y Y		
4.			D D / M M / Y Y Y Y		
5.			D D / M M / Y Y Y Y		

Note: Name and Date of Birth can not be changed at a time.

Signature of the proposer/customer: Place: Date: D D / M M / Y Y Y Y

**ICICI Lombard General Insurance Company Limited**

Mailing Address: Interface Building No.11, 401/402, 4th Floor, New Link Road Malad (W), Mumbai - 400 064.

Registered Office Address: ICICI Lombard House, 414, Veer Savarkar Marg, Near Siddhi Vinayak Temple, Prabhadevi, Mumbai 400 025.

Visit us at www.icicilombard.com • Mail us at customersupport@icicilombard.com

Now One Number for all your Insurance needs 1800 2666 (Toll Free also accessible from your mobile) SMS Facility "HEALTHCLAIM" to 575758

ICICI Lombard General Insurance Company Limited. Insurance is the subject matter of the solicitation. IRDA Reg. No. 115. CIN: L67200MH2000PLC129408. Misc 128, Misc 140.

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