

ICICI LOMBARD GENERAL INSURANCE COMPANY LIMITED

INCIDENT REPORTING FORM FOR CONSUMER PAYMENT PROTECTION POLICY - COMMERCIAL

(The issue of this form is not to be taken as an admission of liability)

1. This form should be filled in by the Insured or an authorized Representative and must be signed and dated in all applicable sections.
2. The issue or acceptance of this form by the Company, must not be construed as an admission of any liability on the Company, nor a waiver of any of the terms and conditions of the insurance contract.
3. Claim form must be filled online or manually or using voice record at Call Centre.
4. Please answer all questions completely. In case of insufficient space, please attach an additional sheet.
5. Please attach all Original bills & receipts pertaining to your claim.

Policy No: _____

1.	DETAILS OF INSURED	
(i)	Name	
(ii)	Address	
(iii)	Pin Code	
(iv)	Mobile No	
(v)	Email ID	
(vi)	Policy No	
2	INSURED NEFT DETAILS FOR CLAIM PAYMENT	
(i)	Name on Bank Account:	
(ii)	Bank Name	
(iii)	Account Number	
(iv)	Branch	
(v)	Account Type	
(vi)	IFSC Code	
(vii)	MICR Codes	

ICICI Lombard General Insurance Company Limited
Consumer Payment Protection Policy - Commercial

IRDA Reg. No. 115

Mailing Address:

601 & 602, 6th Floor, Interface 16,
 New Linking Road, Malad (West)
 Mumbai - 400 064

CIN: L67200MH2000PLC129408

Registered Office Address:

ICICI Lombard House, 414, Veer Savarkar Marg,
 Near Siddhi Vinayak Temple, Prabhadevi,
 Mumbai 400 025

UIN : IRDAN115CPMS0009V01202526

Toll free no : 1800 2666

Alternate no : 86552 22666 (chargeable)

E-mail : customersupport@icicilombard.com

Website : www.icicilombard.com

(viii)	PAN Number	
3	DETAILS OF LOSS	
(i)	Please name the cover under which you are Claiming.	
(ii)	Date, exact time and location of the loss or damage?	
(iii)	Date and exact time of discovering the loss or damage? (if applicable)	
(iv)	Date & time of loss or damage been reported to bank by Beneficiary	
(v)	Beneficiary details such as Name of beneficiary	
(vi)	Please give details of the card / account/ wallet on which unauthorized / fraudulent transaction happened. (if applicable)	
(vii)	Date & time of blocking the card/account/ wallet on which unauthorized/fraudulent transaction happened	
(viii)	Please give full details and description of how the loss or damage occur?	
(ix)	In the event of loss, which Police Station has been notified? (if applicable) Attach a copy of FIR/ Police report.	
(x)	Was the loss incidence reported to Banks, Financial institutions, Travel company, Fintech companies? If yes, attach a copy of the report submitted	
(xi)	Was there any recovery in the loss occurred? If Yes, please provide details.	
(xii)	Any Additional information relevant to claims	
(xiii)	Estimated Loss Amount (in INR)	
4	DETAILS OF OTHER INSURANCE AND PREVIOUS LOSS	
(i)	Is the accident / incidence covered under any other Insurance? If Yes, please provide the following information: i. Name of Insurer ii. Address iii. Phone No. and Email iv. Policy No. v. Period of insurance	
(ii)	Have you incurred any claim before? If Yes, please provide the details	

DECLARATION

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- I/We the above named, do hereby, to the best of my/our knowledge and belief, warrant the truth of the foregoing statements in every respect and agree that if I have made any false or fraudulent statement or there be any suppression or concealment, no claim shall be payable resulting into forfeiture of premium and/or cancellation of policy.
- I/We have received a list of documents with this claim Form and have understood all the requirements to be fulfilled for administration of this claim.
- I/We agree to provide additional information to the Company, if required.
- I/We hereby do give consent that payment of claim amount be made to third person as per the bank details mentioned above/I/We hereby give my/our consent to the Company to verify and obtain my/our identity/address proof as well as the identity /address proof of the insured through Central KYC Registry or UIDAI or through any other modes for the purpose of undertaking KYC

Name:
Date

Signature of Insured/ Claimant:

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