ICICI Lombard Nibhaye Vaade

ICICI Lombard Health Care Claim Form - Domestic Travel

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

ICICI Lombard Health Care

Guidelines for completion of Claim Form
1. Claim form consists of Part A (with annexure), Part B and Part C.
2. Please fill the Part A along with the relevant Annexure as per the desired coverage.
3. Please take print out of the relevant coverage only.
4. Please send the claim form along with the claim documents as shared on LOR for claim proceeding

S No.	Part - A	To be filled by	Required to
1	A1- Policy Details	Insured/Claimant/Nominee	To track Insured details and to ensure timely communication
2	A2- Insured Details		
3	A3- Claimant Details		

S No.	Annexures	Coverage	Page Number (Please tick whichever is applicable) ☑
1	Annexure I	Medical cover	4 ☐
2	Annexure II	Repatriation of remains	4 ☐
3	Annexure III	Checked in baggage loss/delay	5 ☐
4	Annexure IV	Personal accident	6 ☐
5	Annexure V	Trip cancellation & interruption	6 ☐
6	Annexure VI	Trip delay	7 ☐
7	Annexure VII	Missed (flight) connection	8 ☐
8	Annexure VIII	Compassionate visit	8 ☐
9	Annexure IX	Others	9 ☐
	Part B	Insured	For electronic fund transfer to bank account ☐
	Part C - KYC	Insured	As per IRDA guidelines, for claimed amount > ₹100,000 INR ☐

Documents Submitted

Common Documents

S No	Document	Yes	No	Type of Document Original / Photocopy
1	Claim Form			
2	Policy Certificate			
3	Ticket/Boarding pass issued by service provider			
4	Incident letter			
5	Copy of ID proof			
6	Cancelled cheque (in case NEFT form not attested by bank)			
7	Declaration letter (in case if claim being settled into account other than Insureds)			

Specific documents depending on benefit claimed

S No	Document	Yes	No	Type of Document Original / Photocopy
1	Bills and receipt for additional expenses (food / stay/alternate travel arrangement)			
2	Bills and receipt for medical expenses (hospital/investigations/medicines/consultation)			
3	Communication from service provider (trip cancellation/delay , baggage loss/baggage delay)			
4	Refund voucher/details from service provider for cancellation/compensation			
5	PIR (property irregularity report) from service provider			
6	Delivery receipts from service provider			
7	Discharge summary and medical reports			
8	Death certificate/ Post mortem report			
9	FIR/Panchanma			
10	Others pls specify			
11	Others pls specify			

Please send the completely filled and signed claim form along with the supporting claim documents (as per LOR - Letter of requirement) to the below mentioned address for further claim processing

Mailing Address: ICICI Lombard Healthcare, ICICI Bank tower, Plot No 12, Financial district, Nanakramguda, Gachibowli, Hyderabad, Telangana - 500 032

ICICI Lombard Nibhaye Vaade

ICICI Lombard Health Care Claim Form - Domestic Travel

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ICICI Lombard Health Care

Do You Know

- ★ Non-submission of original bills and receipts is the main reason for delay in claim settlements. Please provide the originals & mandatory documents
- ★ To receive update on your claim status, provide your mobile no. & E-mail ID

PART A

(To be filled by Insured)

A1 POLICY DETAILS

Policy No.:

Policy Start Date: D D/ M M/ Y Y Y Y Policy End Date: D D/ M M/ Y Y Y Y

A2 INSURED DETAILS

Full Name: (First) (Middle) (Last)

Date of Birth: D D/ M M/ Y Y Y Y Sex: Male ☐ Female ☐

Current Address:

Address in Country of Residence:

Phone No. Overseas: Phone No. India: (With STD Code)

Mobile No: Email ID:

Passport No.: Claims Ref No.:(As provided)

Every claim has to be accompanied with original ticket/ boarding pass or copy of the passport indicating the travel dates.

A3 CLAIMANT INFORMATION (If different than "Insured Information" above)

Full Name:

Date of Birth: D D/ M M/ Y Y Y Y Sex: Male ☐ Female ☐ Relationship with the Policyholder:

Claimant's Address:

Phone No. (Off): Phone No. (Res):

Email ID:

In what capacity are you making this claim? ☐ Self ☐ Nominee ☐ Insured's Rlative _____ Specify _____

Terms and conditions

1. The Insured shall ensure that the Insured has received, read and understood the terms and conditions as contained in Part II and III of the Policy. If the Insured has not received Part II and Part III of the Policy, please email at customersupport@icicilombard.com.
2. In the event of an Accident or sudden Illness or occurrence of any other contingency covered under the Policy, the Insured shall immediately contact the Help Line number and register his/ her claim furnishing the necessary details.
3. Please note, Deductible amount as mentioned in Policy Schedule must be borne by you.
4. Issuance of the claims form is not an admission of liability or a waiver of terms, conditions & exceptions of the insurance contract.
5. No claim under Accident & Medical Section will be admitted without Doctor's Report as per format.
6. Please answer all questions completely. In case of insufficient space, please attach additional sheets.
7. Please attach original of all bills, receipts, credit card slips pertaining to your claim. Every claim has to be accompanied with original ticket/ boarding pass or copy of passport indicating the travel dates.

DECLARATION / AUTHORISATION (By Insured / On behalf of Insured)

I/We hereby agree, affirm and declare that:

1. The statements/ information given/ stated by me/ us in this claim form are true, correct and complete.
2. The details of all persons having an interest in the property in respect of which the claim is being made are provided as per the proposal form or by way of an endorsement in the policy. Furthermore, save and except as provided or disclosed in this claim form, no claim made hereunder (or the same/ similar claim) has been made or lodged with any other insurance company.
3. No material information which is relevant to the processing of the claim or which in any manner has a bearing on the claim has been withheld or not disclosed.
4. If I/ We have given/ made any false or fraudulent statement/ information, or suppressed or concealed or in any manner failed to disclose material information, the policy shall be void and that I/ We shall not be entitled to all/any rights to recover thereunder in respect of any or all claims, past, present or future.
5. The receipt of this claim form/other supporting/related documents does not constitute or be deemed to constitute an agreement by the Company of the claim and the Company reserves the right to process or reject or require further/additional information and documents in respect of the claim.
6. I do hereby authorize International Subrogation Management (ISM) to inquire and obtain any information regarding my accident. Further, ICICI Lombard is hereby authorized to release any and all information, including copies of pertinent documents, which ISM may deem necessary in order to satisfy their inquiry, If during the investigation, ISM has identified a potential recovery source, allowing the Plan Participant's employer to recover paid benefits, ISM is authorized to release any all records they deem necessary in order to pursue the recovery.

7. The company can, while assessing the claim, call for the additional documents which the Company deems fit for assessment of the claim.
8. I authorize any insurance company, physician, hospital or other healthcare provider, or any other organization, institution or person that may have records, documents or knowledge regarding the Insured to release any information requested regarding this claim and the loss reported.
9. I understand ICICI Lombard General Insurance Company Ltd, or its authorized representatives, for the purpose of evaluating and determining coverage for this claim, will use this information.
10. I know I have a right to receive a copy of this authorization upon request and agree that a photographic or facsimile copy of this authorization is as valid as the original.
11. I agree that this authorization shall be valid for the duration of this claim. I also authorize Assistance Service Provider, on behalf of ICICI Lombard General Insurance Company Limited, to obtain any medical records or information to process this claim.
12. I understand that any person who knowingly and with intent to defraud or deceive any insurance company files a claim containing any materially false, incomplete or misleading information may be subject to prosecution for insurance fraud.

Dated: D D / M M / Y Y Y Y If Claimant, Relationship with the Insured:

Place:

Sign here

Insured's Signature

Sign here

Claimant or authorized person Signature

ANNEXURE - I - Hospitalization Expenses for Injury

Provide Name, address & telephone number of Hospital / Clinic :

Treating Doctor's Name & Qualification

Treating Doctor's Telephone Number : (O) (M) Room / Ward / Bed Number :

Date of Treatment : From D D / M M / Y Y Y Y To : D D / M M / Y Y Y Y Date of onset of symptoms: D D / M M / Y Y Y Y

Attending Doctor's Report

Date doctor contacted : D D / M M / Y Y Y Y Time : HH : MM

Nature of Ailment :

State diagnosis and nature of treatment provided :

When did patient's symptoms first appear ?

Describe any other disease or infirmity affecting present condition :

Was the ailment due to Pregnancy : Yes No Was the aliment aggravated due to any pre-existing condition ? Yes No

If yes, please give details :

Medical Evacuation*

Can the Patient be evacuated back to the Republic of India ? Yes No

Medical Doctor's Signature and Date : D D / M M / Y Y Y Y *To be filled only for International travel claim

Medical Treatment Expenses Details :

Sr. No.	Details of Medical treatment/Medical evacuation / expenses	Date	Expenses in Foreign Currency / INR
1.	Hospital Bill	D D / M M / Y Y Y Y	
2.	Medical Bills	D D / M M / Y Y Y Y	
3.	Others (Please Specify)	D D / M M / Y Y Y Y	
4.	Others (Please Specify)	D D / M M / Y Y Y Y	
5.	Others (Please Specify)	D D / M M / Y Y Y Y	
	Total		

Documents to be submitted in support of the claim :

1. Medical reports and discharge summary issued by the Hospital furnishing the name of the Insured, period of treatment, details of treatment rendered.
2. Bills/receipts for :
   a. Charges paid towards Hospital accommodation, nursing facilities and other medical services rendered;
   b. Fees paid to the Medical Practitioner, special nursing charges, etc.
   c. Charges incurred towards any and all test and/or examinations rendered in connection with the treatment
   d. Charges incurred towards medicines or drugs purchased from outside duly supported by the prescriptions of the Medical Practitioner attending on the insured.
3. Any other additional document as required by Insurer.

ANNEXURE - II - Repatriation of Remains

Cause / Circumstances of death :

Date of death of insured : D D / M M / Y Y Y Y

Details of expenses incurred for repatriation of Remains /Funeral :

Sr. No.	Details of treatment / expenses	Date	Expenses in Foreign Currency / INR
1.	Hospital Bill	D D / M M / Y Y Y Y	(Please Write Here)
2.	Medical Bills	D D / M M / Y Y Y Y	(Please Write Here)
3.	Others (Please Specify)	D D / M M / Y Y Y Y	(Please Write Here)
4.	Others (Please Specify)	D D / M M / Y Y Y Y	(Please Write Here)
5.	Others (Please Specify)	D D / M M / Y Y Y Y	(Please Write Here)
	Total		

Documents to be submitted in support of the claim :

1. Photocopy of the death certificate providing the details of the place, date and time, and the circumstances and cause of the death (photocopy of the postmortem certificate wherever required by the Third Party Administrator), issued by the appropriate authority where the contingency has arisen.
2. Proof for expenses incurred towards disposal of the mortal remains.
3. In case of transportation of the body of the deceased to the Country of Residence of the Insured, the receipt for expenses incurred towards preparation and packing of the mortal remains of the deceased and also for the air transportation of the mortal remains of the deceased to the Country of residence of the Insured.

ANNEXURE - III - Checked -in Baggage Loss / Delay :

Describe when & where the Loss / Delay took place :

State the extent of Delay / Loss : (In hrs) Place of Delay / Loss :

Name the common carrier : No. of Hours of bag delay :

Flight Details :

1. Flight No. : From : To :
2. Flight No. : From : To :

Actual Date & Time of Arrival of flight at Port : D D / M M / Y Y Y Y H H M M

Actual Date & Time when Bags were delivered : D D / M M / Y Y Y Y H H M M

Had the common carrier been notified at the time of loss ? Yes No (Tick the appropriate)

Property Irregularity Report (PIR) number from Airline/Common Carrier :

Details of compensation required from carrier

Details of items purchased / lost / expenses.

Sr. No.	Item Purchased / Items Lost	Date of Purchase	Cost in Foreign Currency (In INR for loss claim)
	(Please Write Here)	D D / M M / Y Y Y Y	(Please Write Here)
	(Please Write Here)	D D / M M / Y Y Y Y	(Please Write Here)
	(Please Write Here)	D D / M M / Y Y Y Y	(Please Write Here)
	(Please Write Here)	D D / M M / Y Y Y Y	(Please Write Here)
	(Please Write Here)	D D / M M / Y Y Y Y	(Please Write Here)
			Total :
			Compensation From Airlines :
			Net Amount :

Documents to be submitted in support of the claim for Checked-in Baggage Loss :

1. Statement of claim furnishing the details of items contained in the Checked-in Baggage.
2. Property irregularity report issued by the Common Carrier.
3. Voucher of the Common Carrier for the compensation paid for the non-delivery/short delivery of the Checked-In Baggage.
4. Copies of correspondence exchanged, if any, with the Common Carrier in connection with the non-delivery/short delivery of the Checked-in Baggage.

In case of compensation from the Common Carrier having been received after payment of the claim by the company hereunder, the Insured shall repay to the Company such amount in excess of his/her loss after taking into account the amount of claim received from the Company and at that received from the Common Carrier. In case the undelivered Checked-in Baggage is subsequently traced by the Common Carrier and offered for delivery to the Insured, the Insured shall take delivery of the Checked-in Baggage and refund the amount paid by the Company hereunder. In case of delivery of part of the Checked-In Baggage, the amount paid by the Company attributable to such Checked-In Baggage shall be refunded by the Insured to the Company.

Documents to be submitted in support of the claim Checked-In Baggage Delay :

1. Property irregularity report stating the scheduled time delivery and actual time of delivery of the Checked-In Baggage issued by the Common Carrier;
2. Voucher of the Common Carrier for the compensation paid for the delay in delivery of the Checked-In Baggage;
3. Copies of correspondence exchanged, if any, with the Common Carrier in connection with the delay in delivery of the Checked-In Baggage.
4. Any additional documents as required by the Insurer.

ANNEXURE - IV - Personal Accident

Please state circumstances of accident i.e. how, when, where it took place :

Nature of Injury :

State diagnosis and nature of treatment / surgery under taken :

Provide name, address & telephone umber of Hospital / Clinic :

Treating Doctor's Name & Qualifications :

Treating Doctor's Telephone Number : (O) (M) Room /Ward / Bed Number :

Dates of treatment : From : D D / M M / Y Y Y Y To : D D / M M / Y Y Y Y

Attending Doctor's Report

Date doctor contacted : D D / M M / Y Y Y Y H H : M M

Nature of Ailment :

State diagnosis and nature of treatment provided :

Describe any other disease or infirmity affecting present condition

Was the accident due to Pregnancy : Yes ☐ No ☐ (Tick the appropriate)

Was the accident due to any pre-existing condition : Yes ☐ No ☐ (Tick the appropriate)

If yes, please give details :

Can the patient be evacuated back to the Republic of India ? Yes ☐ No ☐ (Tick whichever appropriate)

Loss Incurred (Please tick) :

☐ Death

☐ Permanent Total Disability : (Details) Write Here

☐ Permanent Partial Disability : (Details) Write Here

Medical Doctor's Signature and Date : D D / M M / Y Y Y Y

Documents to be submitted in support of the claim :

1. Medical reports giving the details of the Accident, nature of Injury and the extent of disability. Certified by Medical Practitioner.
2. In case of death of the Insured, death certificate issued by the Medical Practitioner who attended on the Insured.
3. Postmortem certificate to be produced if required by the Third Party Administrator. Police report in original in case the Accident shall have taken place in a public place or premises.

ANNEXURE - V - Trip Cancellation and Interruption

☐ Trip Cancelled / ☐ Trip Interrupted ☐ Also claiming for Trip Regained (Tick whichever appropriate)

Reason for Trip Cancellation / Interruption :

Please detail out the above reason for trip cancellation / interruption (how, where, when and reason for the same) :

Trip Cancellation / Interruption date : D D / M M / Y Y Y Y

Original Travel Dates : From : D D / M M / Y Y Y Y To : D D / M M / Y Y Y Y

Person Affected and Relationship with the Insured : (If not the insured, please also provide address and contact details)

Details of Losses / Expenses Incurred :

Sr. No.	Loss / Expenses Details	Amount
	(Please Write Here)	(Please Write Here)
	(Please Write Here)	(Please Write Here)
	(Please Write Here)	(Please Write Here)
	(Please Write Here)	(Please Write Here)
		Total :

Documents to be submitted in support of the claim :

1. In case of cancellation of the Trip either in the City of Residence of the Insured or any other intermediate place forming part of the Trip by the Common Carrier solely resulting from contingencies namely Earthquake, Storm, Flood, Inundation, cyclone, tempest & Terrorism, fog (if specifically covered) duly completed claims form to be accompanied by :
   a. Confirmation of cancellation of the Trip from the Common Carrier detailing the circumstances of cancellation;
   b. Original used air ticket indicating the cost the ticket and receipt for the refund of the fare of the Common Carrier towards the cancelled portion of the Trip the Cancellation charges retained;
   c. Original bill and a receipt/letter obtained from the hotel and /or guest house and/or any other paid residential accommodation (available for fee) indicating the amount paid for the accommodation, the refund given and the cancellation charges retained, wherever such accommodation has be arranged at the place of cancellation of the Trip;
   d. Used air ticket in original for return journey from the place of cancellation to the City of residence of the Insured which indicate the cost of the tickets together with the receipts for the refunds obtained towards the unfulfilled portion of the Trip.
2. In case the cancellation of the Trip shall result because of personal contingencies covered hereunder or a decision taken at the instance of the Insured arising out of the contingencies namely Earthquake, Storm, Flood, inundation, cyclone, tempest & Terrorism, fog (if specifically covered) the duly completed claims form to be accompanied by :
   a. A declaration from the Insured furnishing the circumstances that complied him/her to cancel the Trip;
   b. Medical evidence as may be required by the Third Party Administrator in case of the cancellation of the Trip arising out of personal contingencies of the Insured or his/her Immediate Family;
   c. Receipt for the refund of the fare of the Common Carrier towards the cancelled portion of the Trip indicating the cancellation charges retained;
   d. Receipt/letter obtained from the for the hotel and /or guest house and/or any other residential accommodation (available for a fee) indicating the cancellation charges retaired, wherever such accommodation has be arranged at the place of cancellation of the Trip;
   e. Used air ticket or boarding pass in original for return journey from the place of cancellation to the City of Residence of the Insured together with the receipts for the refunds obtained towards the unfulfilled portion of the Trip.
3. In case the cancellation charges either for the Trip or part of it or in relation to the accommodation in a hotel/guest house/other residential accommodation is waived to the advantage of the Insured subsequent to any settlement of claim under this Benefit, the Insured shall forthwith return the sum paid by the Company to the extent of such waiver.

ANNEXURE - VI - Trip Delay

Reason for Trip Delay :

Please detail out the reason for trip delay (how, where, when, what was lost and reason for the same above)

Original Travel Dates : From : D D / M M / Y Y Y Y To : D D / M M / Y Y Y Y Trip delayed on : D D / M M / Y Y Y Y

Person Affected and Relationship with the Insured : (If not the Insured, please also provide address and contact details)

Details of Losses / Expenses Incurred :

Sr. No.	Loss / Expenses Details	Amount
	(Please Write Here)	(Please Write Here)
	(Please Write Here)	(Please Write Here)
	(Please Write Here)	(Please Write Here)
	(Please Write Here)	(Please Write Here)
		Total :

Documents to be submitted in support of the claim :

In case of delay of the Trip, at any places forming part of the Trip, by the Common Carrier solely resulting from contingencies namely earthquake, storm, flood, inundation, cyclone, tempest & terrorism, fog (if specifically covered) duly completed claims form to be accompained by, confirmation of delay of the Trip from the Common Carrier detailing the circumstances of delay. Also require copy of receipts for all expenses incurred and any additional document as required by Insured.

ANNEXURE - VII - Missed (Flight) Connection

Original Travel Schedule : (Please give date and time of all flights, mentioning the original and actual arrival and departure times. Please also mention the name of carriers and flight numbers)

S. No.	Date of Travel	Fight Name	Place of Origin	Time of Departure	Destination Name	Time of Arrival
	D D / M M / Y Y Y Y			H H : M M		H H : M M
	D D / M M / Y Y Y Y			H H : M M		H H : M M
	D D / M M / Y Y Y Y			H H : M M		H H : M M
	D D / M M / Y Y Y Y			H H : M M		H H : M M
	D D / M M / Y Y Y Y			H H : M M		H H : M M
	D D / M M / Y Y Y Y			H H : M M		H H : M M

Which flight was delayed causing a missed connection ?

Reason for delay of the flight :

Details of expenses due to Missed Connection :

Sr. No.	Expenses	Amount
	(Please Write Here)	(Please Write Here)
	(Please Write Here)	(Please Write Here)
	(Please Write Here)	(Please Write Here)
	(Please Write Here)	(Please Write Here)
		Total :

Documents to be submitted in support of the claim :

1. The confirmation from the Common Carrier of the delayed flight as to the expected time of arrival and the actual time of arrival at the port of delay together with the reasons for delay.
2. Unused ticket for the ongoing flight (Missed Flight) with an endorsement of the Common Carrier of cancellation of the same.
3. Certificate from the Common Carrier of the Missed Flight that the fare for the part of the Trip covered by the Missed Flight is forfeited in full or in part together with the amount of forfeiture.
4. Original used ticket obtained afresh towards the alternative flight for the part of the Trip covered by the Missed Flight indicating the amount paid as fare.
5. Any additional document as required by Insurer.

In the event of the forfeited amount by the Common Carrier for the Missed Flight being refunded / returned to the Insured, subsequent to any payment under this section, the Insured shall return the amount so refunded in full.

ANNEXURE - VIII - Compassionate Visit

Person Hospitalised : ☐ Insured ☐ Family Member (Tick whichever applicable)

Name of the person hospitalized (if not insured) :

Relationship with the insured :

Provide name, address & telephone number of Hospital / Clinic :

Treating Doctor's Name & Qualifications :

Treating Doctor's Telephone Number (O) : (M) : Room /Ward/Bed Number :

Dates of hospitalisation : From : D D / M M / Y Y Y Y To : D D / M M / Y Y Y Y

Date of onset of symptoms : D D / M M / Y Y Y Y

Attending Doctor's Report :

Date doctor contacted : D D / M M / Y Y Y Y Time : H H : M M

State diagnosis and nature of treatment provided :

When did patient's symptoms first appear : D D / M M / Y Y Y Y

Describe any other disease or infirmity affecting present condition :

Was the ailment due to Pregnancy : Yes ☐ No ☐ Was the ailment aggravated due to any pre-existing condition ?: Yes ☐ No ☐

If yes, please give details :

Can the patient be evacuated back to the Republic of India ? Yes ☐ No ☐

Estimated time the patient would continue to be in the hospital:

Medical Doctor's Signature and Date : _____ D D / M M / Y Y Y Y

Expenses Details

Sr. No.	Details of Expenses	Date	Expenses in Foreign Currency / INR
1.	(Please Write Here)	D D / M M / Y Y Y Y	(Please Write Here)
2.	(Please Write Here)	D D / M M / Y Y Y Y	(Please Write Here)
3.	(Please Write Here)	D D / M M / Y Y Y Y	(Please Write Here)
4.	(Please Write Here)	D D / M M / Y Y Y Y	(Please Write Here)
5.	(Please Write Here)	D D / M M / Y Y Y Y	(Please Write Here)
	Total		

Documents to be submitted in support of the Claim :

1. A Certificate from the Medical Practitioner recommending the presence in the form of special assistance to be rendered by a member of the Family or near relative during the entire period of Hospitalization. Certificate to also specify the minimum period of Hospitalization.
2. Discharge summary of the Hospital furnishing details - date of admission, date of discharge, and the presence of the member of the Family or near relative on all days of Hospitalization.
3. Original ticket used for the travel to and fro by the member of the Family or near relative.
4. Any additional document as required by Insurer.

ANNEXURE - IX - Other Benefits

Benefit/loss for which claimed:

Expenses Details

Sr. No.	Details of Expenses evacuation / expenses	Date	Expenses in Foreign Currency / INR
1.	(Please Write Here)	D D / M M / Y Y Y Y	(Please Write Here)
2.	(Please Write Here)	D D / M M / Y Y Y Y	(Please Write Here)
3.	(Please Write Here)	D D / M M / Y Y Y Y	(Please Write Here)
4.	(Please Write Here)	D D / M M / Y Y Y Y	(Please Write Here)
5.	(Please Write Here)	D D / M M / Y Y Y Y	(Please Write Here)

ICICI Lombard
Nibhaye Vaade

Part - B - NEFT Form
(For Direct Electronic Fund Transfer)

ALL CLAIM SETTLEMENTS SHOULD BE MADE THROUGH NEFT (AS PER IRDA CIRCULAR), PLEASE PROVIDE YOUR BANK ACCOUNT DETAILS.

1. Patient's Name: (in respect of whom claim is made):

2. Policy Number:

3. Card No./ UHID No.:

4. Group/Company Name (for Group/Corporate policy holders):

5. Claim Number (if allotted): **6. Mobile/ Contact No.:**

7. Email:

8. As per IRDA Circular No.: IRDA/F&A/CIR/GLD/056/02/2014, Proposer's/ policy holder's bank account details are mandatory to process the claim through EFT.

Please provide ANY ONE of the below documents of proposer/ policy holder-

- ☐ Please provide a self-attested copy of a valid Identity proof of the Proposer/Policy holder (provide any of the mentioned documents in Proof of Identity under Part-D)
- ☐ Cancelled cheque copy
- ☐ Bank attested copy of Passbook with IFSC code

9. Please provide the below details (all fields are compulsory)

- Proposer (policy holder)/ Employee name*(as per bank records):
- Proposer/ policy holder Bank account no.:
- Name of the bank:
- Branch name:
- Address of the bank:
- IFSC code no. of the bank: (should be same as per the provided cheque leaflet)
- PAN no. of Proposer:

***Proposer/ Policy holder is the person who has paid premium for the policy.**
For Retail policy, Name & Account details of Proposer required. For Corporate policy, Employee Name & Account details required.

Terms and Conditions for Payments through RTGS/ NEFT

1. The details provided by the Proposers/ policy holder in the Mandate Form shall be considered as final and ICICI Lombard General Insurance Company Ltd. shall not be responsible for cross verification of any of the details provided therein.
2. The RTGS/ NEFT facility shall be effective for the respective Proposer(s)/ policy holder within 15 days of the receipt of the Mandate Form by ICICI Lombard General Insurance Company Ltd. and/ or within such period as may be reasonably required by ICICI Lombard General Insurance Company Ltd. to activate the RTGS/ NEFT facility.
3. The Proposer/ policy holder agrees that under the RTGS/ NEFT facility, there may be a risk of non-payment in the Proposer/ policy holder Accounts No. on the day of the credit of payments due to change in the applicable regulations pertaining to RTGS/ NEFT facility or due to any other reasons without any fault/ inaction/ failure on part of ICICI Lombard General Insurance Company or any factor beyond the control of ICICI Lombard General Insurance Company Limited.
4. The Proposer/ policy holder agrees to indemnify, without delay or demur, ICICI Lombard General Insurance Company Ltd. and its agents and keep ICICI Lombard General Insurance Company Ltd. and its agent indemnified harmless at all times from and against any and all claims, damages, losses, costs, and expenses (including attorney's fees) which ICICI Lombard General Insurance Company Ltd. may suffer or incur, directly or indirectly, arising from or in connection with, amongst other things, either of the aforesaid reasons stated in above clauses.
5. ICICI Lombard General Insurance Company Ltd. May sub-contract and employ agents to carry out any of its obligations under the RTGS/ NEFT facility. The Proposer/ policy holder may discontinue or terminate the use of RTGS/ NEFT facility by giving a minimum of 15 days prior written notice to ICICI Lombard General Insurance Company Ltd. The notice of, such termination should be given to ICICI Lombard only at its corporate address and be addressed at ICICI Lombard GIC Ltd., ICICI Lombard House (Old Tata Press Building), 414, Veer Savarkar Marg, Near Siddhi Vinayak Temple, Prabhadevi, Mumbai - 400025.
6. A confirmation of the receipt of termination notice given by the Proposer/ policy holder will be acknowledged through a confirmation letter by ICICI Lombard General Insurance Company Ltd. In no case can the Proposer/ policy holder construe his termination notice as effective unless a confirmation has been provided by ICICI Lombard to the Proposer/ policy holder stating the date of receipt of such communication by the Proposer/ policy holder.
7. The Proposer/ policy holder agrees that transaction(s) through RTGS/ NEFT facility may attract inward RTGS/ NEFT charges, which if levied by the Proposer's/ policy holder's bank, shall be borne by the Proposer/ policy holder only.
8. ICICI Lombard has the absolute discretion to amend or supplement any Terms and Condition stated herein at any time and will endeavor to give prior notice of ten days for such changes wherever feasible for the Terms and Conditions to be applicable. By using the new services, or at the completion of such period, whichever is earlier, the Proposer/ policy holder shall be deemed to have accepted the changed Terms and Conditions.
9. Submission of documents or bank details or any other information does not in any way, shape or form, imply or express or suggest admission of liability by the company.
10. Notices under these Terms and Conditions may be given in writing by delivering them by hand or e-mail or on ICICI Lombard General Insurance Company Ltd. website www.icicilombard.com or by sending them by post to the last address of the Proposer/ policy holder.
11. These Terms and Conditions will be governed by the laws of India and any legal action or proceedings arising out of these Terms and Conditions shall be initiated in the courts or tribunals at Mumbai in India.
12. I/We further undertake to refund any excess amount whether demanded by ICICI Lombard General Insurance Company Ltd. or not, which has been credited in excess to my account at any time due to any reason within 7 days of such receipt of such communication from ICICI Lombard of such excess credit or such information of excess credit coming to the knowledge of the Proposer/ policy holder through any other source.
13. I/We agree that my/ our claim payment will be credited from the date ICICI Lombard General Insurance Company Ltd. gets confirmation from its bankers, This facility will continue unless it is revoked by any party and any issuance of relevant credit instruction from ICICI Lombard General Insurance Company Ltd. to its bankers will be valid till such instruction is complete irrespective of the fact that the notice period has expired provided such a credit request has been made by ICICI Lombard General Insurance Company Ltd. before the expiry of the notice period of the Proposer/ policy holder.

Account holder's Signature

Part C – Know Your Customer (KYC)

With reference to IRDAI Circular No. IRDAI/SDD/MISC/CIR/135/07/2016,
KYC details are required for Individual/ Retail policy holders, if the total claimed amount exceeds ₹100,000

CENTRAL KYC REGISTRY | Know Your Customer (KYC) Application Form | Individual

Important Instructions:

A) Fields marked with '*' are mandatory fields.
B) Please fill the form in English and in BLOCK letters.
C) Please fill the date in DD-MM-YYYY format.
D) Please read section wise detailed guidelines / instructions at the end.
E) List of State / U.T code as per Indian Motor Vehicle Act, 1988 is available at the end.
F) List of two character ISO 3166 country codes is available at the end.
G) KYC number of applicant is mandatory for update application.
H) For particular section update, please tick (✓) in the box available before the section number and strike off the sections not required to be updated.

To be filled by Proposer: Application Type* ☐ New ☐ Update

KYC Number _____ *(Mandatory for KYC update request)*

If KYC Number is not available, please fill this Central-KYC (C-KYC) form

☐ 1. PERSONAL DETAILS (Please refer instruction **A** at the end)

	Prefix	First Name	Middle Name	Last Name
☐ Name* (Same as ID proof)				
Maiden Name (If any*)				
Father / Spouse Name*				
Mother Name*				

Date of Birth* D D – M M – Y Y Y Y

Gender* ☐ M- Male ☐ F- Female ☐ T-Transgender

Marital Status* ☐ Married ☐ Unmarried ☐ Others

Citizenship* ☐ IN- Indian ☐ Others (ISO 3166 Country Code ☐☐)

Residential Status* ☐ Resident Individual ☐ Non Resident Indian ☐ Foreign National ☐ Person of Indian Origin

Occupation Type* ☐ S-Service (☐ Private Sector ☐ Public Sector ☐ Government Sector) ☐ O-Others (☐ Professional ☐ Self Employed ☐ Retired ☐ Housewife ☐ Student) ☐ B-Business ☐ X- Not Categorised

PHOTO

Signature / Thumb Impression

☐ 2. TICK IF APPLICABLE ☐ RESIDENCE FOR TAX PURPOSES IN JURISDICTION(S) OUTSIDE INDIA (Please refer instruction **B** at the end)

ADDITIONAL DETAILS REQUIRED* (Mandatory only if section 2 is ticked)

ISO 3166 Country Code of Jurisdiction of Residence* ☐☐

Tax Identification Number or equivalent (If issued by jurisdiction)* _____

Place / City of Birth* _____ ISO 3166 Country Code of Birth* ☐☐

☐ 3. PROOF OF IDENTITY (PoI)* (Please refer instruction **C** at the end)

(Certified copy of any one of the following Proof of Identity[PoI] needs to be submitted)

☐ A- Passport Number _____ Passport Expiry Date D D – M M – Y Y Y Y

☐ B- Voter ID Card _____

☐ C- PAN Card _____

☐ D- Driving Licence _____ Driving Licence Expiry Date D D – M M – Y Y Y Y

☐ E- UID (Aadhaar) _____

☐ F- NREGA Job Card _____

☐ Z- Others (any document notified by the central government) _____ Identification Number _____

☐ S- Simplified Measures Account - Document Type code ☐☐ Identification Number _____

4. PROOF OF ADDRESS (PoA)*

☐ 4.1 CURRENT / PERMANENT / OVERSEAS ADDRESS DETAILS (Please see instruction **D** at the end)

(Certified copy of any one of the following Proof of Address [PoA] needs to be submitted)

Address Type* ☐ Residential / Business ☐ Residential ☐ Business ☐ Registered Office ☐ Unspecified

Proof of Address* ☐ Passport ☐ Driving Licence ☐ UID (Aadhaar) ☐ Voter Identity Card ☐ NREGA Job Card ☐ Others _____ please specify _____ ☐ Simplified Measures Account - Document Type code ☐☐

Address

Line 1* _____

Line 2 _____

Line 3 _____ City / Town / Village* _____

District* _____ Pin / Post Code* _____ State / U.T Code* ☐☐ ISO 3166 Country Code* ☐☐

☐ 4.2 CORRESPONDENCE / LOCAL ADDRESS DETAILS * (Please see instruction **E** at the end)

☐ Same as Current / Permanent / Overseas Address details (In case of multiple correspondence / local addresses, please fill '**Annexure A1**')

Line 1*

Line 2

Line 3 City / Town / Village*

District* Pin / Post Code* State / U.T Code* ISO 3166 Country Code*

☐ 4.3 ADDRESS IN THE JURISDICTION DETAILS WHERE APPLICANT IS RESIDENT OUTSIDE INDIA FOR TAX PURPOSES* (Applicable if section 2 is ticked)

☐ Same as Current / Permanent / Overseas Address details ☐ Same as Correspondence / Local Address details

Line 1*

Line 2

Line 3 City / Town / Village*

State* ZIP / Post Code* ISO 3166 Country Code*

☐ 5. CONTACT DETAILS (All communications will be sent on provided

T – Tel. (Res) – Mobile –

FAX – Email ID

☐ 6. DETAILS OF RELATED PERSON (In case of additional related persons, ple ase fill 'Annexure B1') (please refer instruction **G** at the end)

☐ Addition of Related Person ☐ Deletion of Related Person KYC Number of Related Person (if available*)

Related Person Type* ☐ Guardian of Minor ☐ Assignee ☐ Authorized Representative

Name* Prefix First Name Middle Name Last Name

(If KYC number and name are provided, below details of section 6 are optional) el. (Off)

PROOF OF IDENTITY [PoI] OF RELATED PERSON* (Please see instruction (**H**) at the end)

☐ A- Passport Number Passport Expiry Date D D – M M – Y Y Y Y

☐ B- Voter ID Card

☐ C- PAN Card

☐ D- Driving Licence Driving Licence Expiry Date D D – M M – Y Y Y Y

☐ E- UID (Aadhaar)

☐ F- NREGA Job Card

☐ Z- Others (any document notified by the central government) Identification Number

☐ S- Simplified Measures Account - Document Type code Identification Number

☐ 7. REMARKS (If any) Mobile no. / Email-ID) (Please refer instruction **F** at the end)

8. APPLICANT DECLARATION

- I hereby declare that the details furnished above are true and correct to the best of my knowledge and belief and I undertake to inform you of any changes therein, immediately. In case any of the above information is found to be false or untrue or misleading or misrepresenting, I am aware that I may be held liable for it.
- I hereby consent to receiving information from Central KYC Registry through SMS/Email on the above registered number/email address.

Date : D D – M M – Y Y Y Y Place :

[Signature / Thumb Impression]

Signature / Thumb Impression of Applicant

9. ATTESTATION / FOR OFFICE USE ONLY

Documents Received ☐ Certified Copies

KYC VERIFICATION CARRIED OUT BY

Date D D – M M – Y Y Y Y

Emp. Name

Emp. Code

Emp. Designation

Emp. Branch

[Employee Signature]

INSTITUTION DETAILS

Name

Code

[Institution Stamp]

CENTRAL KYC REGISTRY | Instructons / Check list / Guidelines for filling Individual KYC Applicaton Form

General Instructons:

1 Fields marked with '*' are mandatory fields.
2 Tick '☒' wherever applicable.
3 Self-Certficaton of do cuments is mandatory.
4 Please fill the form in English and in BLOCK Leters.
5 Please fill all dates in DD-MM-YYYY format.
6 Wherever state code and country code is to be furnished, the same should be the two -digit code as per Indian Motor Vehicle, 1988 and ISO 3166 country code respectvely list of which is available at the end.
7 KYC number of applicant is mandatory for updat ion of KYC detail s.
8 For part cular secton update, ple ase tck (☒) in the box avail able before the secton number and strike off the sectons not required to be updated.
9 In case of 'Small Account type' only personal detail s at secton number 1 a nd 2, photograph, signature and self-certficaton required.

A Clarificaton / Guide lines on filling 'Personal Details' secton

1 **Name**: Please state the name with Prefix (Mr/Mrs/Ms/Dr/etc .). The name should match the name as mentoned in the Pr oof of Identty submited failing which the applicaton is liable to be rejected.
2 Either **father's name or spouse's** name is to be mandatorily furnished. In case PAN is not ava ilable father's name is mandatory.

B Clarificaton / Guide lines on filling details if applicant residence for tax purposes in jurisdicton(s) outside India

1 **Tax ident ficaton Number (TIN):** TIN need not be reported if it has not been i ssued by the j urisdicton. However, if the said jurisdicton has i ssued a high integrity number with an equivalent level of identficaton (a "Functonal equivalent"), the same may be reported. Examples of that type of number for indivi dual include, a social security/insurance number, citzen/personal identficaton/services code/number, and resident registraton number)

C Clarificaton / Guide lines on filling 'Proof of Identty [PoI]' secton

1 If driving license number or passport is provided as pr oof of identty then expiry date is to be ma ndatorily furnished.
2 Menton identficaton / reference number if 'Z - Others (any document notfied by the central government)' is tcked.
3 In case of Simplified Measures Accounts for verifying the identty of the applicant, any one of the following documents can also be submited and undernoted relevant code may be mentoned in point 3 (S).

Document Code	Descripton
01	Identty card with app licant's photograph issued by Central/ State Government Departments, Statutory/ Regulatory Authorites, Pub lic Sector Undertakings, Scheduled Commercial Banks, and Public Financial Insttutons.
02	Leter i ssued by a gazeted officer, with a duly atested photograph of the person.

D Clarificaton / Guide lines on filling 'Proof of Address [PoA] - Current / Permanent / Overseas Address deta ils' secton

1 PoA to be submited only if the submited PoI does not have an address or address as per P oI is invalid or not in force.
2 State / U.T Code a nd Pin / Post Code will not be mandatory for Overseas addresses.
3 In case of Simplified Measures Accounts for verifying the address of the applicant, any one of the following documents can also be submited and undernoted relevant code may be mentoned in point 4.1.

Document Code	Descripton
01	Utlity bi ll which is not more than two months old of any service provider (ele ctricity, telephone, post -paid mob ile phone, piped gas, water bill).
02	Property or Municipal Tax receipt.
03	Bank account or Post Office s avings bank a ccount statement.
04	Pension or fam ily pension payment orders (PPOs) i ssued to retred employees by Government Departments or Pub lic Sector Undertakings, if they contain the address.
05	Leter of a llotment of a ccommodaton from employer i ssued by State or Central Government departments, statutory or regulatory bodies, public sector undertakings, scheduled commercial banks, financial insttutons and listed companies. Si milarly, leave and license agreements with such employers allot ng official accommodaton.
06	Documents issued by Government departments of foreign jurisdictons and leter issued by Foreign Emba ssy or Mission in India.

E Clarificaton / Guide lines on filling 'Proof of Address [PoA] - Correspondence / Local Address details' secton

1 To be fi lled only in case the PoA is not the local address or address where the customer is cu rrently residing. No separate P oA is required to be submited.
2 In case of multple co rrespondence / local addresses, Please fill '**Annexure A1'**

F Clarificaton / Guide lines on filling 'Contact details' secton

1 Please menton two - digit country code and 10 digit mobile number (e.g. for Indian mob ile number menton 91 -9999999999).
2 Do not add '0' in the beginning of Mobile number.

G Clarificaton / Guide lines on filling 'Related Person deta ils' secton

1 Provide KYC number of related person if ava ilable.

H Clarificaton / Guide lines on filling 'Related Person details – Proof of Identty [PoI] of Related Person' secton

1 Menton identficaton / reference number if 'Z - Others (any document notfied by the central government)' is tcked.

List of two – digit state / U.T codes as per Indian Motor Vehicle Act, 1988

State / U.T	Code
Andaman & Nicobar	AN
Andhra Pradesh	AP
Arunachal Pradesh	AR
Assam	AS
Bihar	BR
Chandigarh	CH
Chat sgarh	CG
Dadra and Nagar Haveli	DN
Daman & Diu	DD
Delhi	DL
Goa	GA
Gujarat	GJ
Haryana	HR

State / U.T	Code
Himachal Pradesh	HP
Jammu & Kashmir	JK
Jharkhand	JH
Karnataka	KA
Kerala	KL
Lakshadweep	LD
Madhya Pradesh	MP
Maharashtra	MH
Manipur	MN
Meghalaya	ML
Mizoram	MZ
Nagaland	NL
Orissa	OR

State / U.T	Code
Pondicherry	PY
Punjab	PB
Rajasthan	RJ
Sikkim	SK
Tamil Nadu	TN
Telangana	TS
Tripura	TR
Utar Pra desh	UP
Utarakhand	UA
West Bengal	WB
Other	XX

List of ISO 3166 two- digit Country Code

Country	Country Code	Country	Country Code	Country	Country Code	Country	Country Code
Afghanistan	AF	Dominican Republic	DO	Libya	LY	Saint Pierre and Miquelon	PM
Aland Islands	AX	Ecuador	EC	Liechtenstein	LI	Saint Vincent and the Grenadines	VC
Albania	AL	Egypt	EG	Lithuania	LT	Samoa	WS
Algeria	DZ	El Salvador	SV	Luxembourg	LU	San Marino	SM
American Samoa	AS	Equatorial Guinea	GQ	Macao	MO	Sao Tome and Principe	ST
Andorra	AD	Eritrea	ER	Macedonia, the former Yugoslav Republic of	MK	Saudi Arabia	SA
Angola	AO	Estonia	EE	Madagascar	MG	Senegal	SN
Anguilla	AI	Ethiopia	ET	Malawi	MW	Serbia	RS
Antarctca	AQ	Falkland Islands (Malvinas)	FK	Malaysia	MY	Seychelles	SC
Antgua and Barbuda	AG	Faroe Islands	FO	Maldives	MV	Sierra Leone	SL
Argentna	AR	Fiji	FJ	Mali	ML	Singapore	SG
Armenia	AM	Finland	FI	Malta	MT	Sint Maarten (Dutch part)	SX
Aruba	AW	France	FR	Marshall Islands	MH	Slovakia	SK
Australia	AU	French Guiana	GF	Martni que	MQ	Slovenia	SI
Austria	AT	French Polynesia	PF	Mauritania	MR	Solomon Islands	SB
Azerbaijan	AZ	French Southern Territories	TF	Mauritus	MU	Somalia	SO
Bahamas	BS	Gabon	GA	Mayote	YT	South Africa	ZA
Bahrain	BH	Gambia	GM	Mexico	MX	South Georgia and the South Sandwich Islands	GS
Bangladesh	BD	Georgia	GE	Micronesia, Federated States of	FM	South Sudan	SS
Barbados	BB	Germany	DE	Moldova, Republic of	MD	Spain	ES
Belarus	BY	Ghana	GH	Monaco	MC	Sri Lanka	LK
Belgium	BE	Gibraltar	GI	Mongolia	MN	Sudan	SD
Belize	BZ	Greece	GR	Montenegro	ME	Suriname	SR
Benin	BJ	Greenland	GL	Montserrat	MS	Svalbard and Jan Mayen	SJ
Bermuda	BM	Grenada	GD	Morocco	MA	Swaziland	SZ
Bhutan	BT	Guadeloupe	GP	Mozambique	MZ	Sweden	SE
Bolivia, Plurinat onal State of	BO	Guam	GU	Myanmar	MM	Switzerland	CH
Bonaire, Sint Eustatus and Saba	BQ	Guatemala	GT	Namibia	NA	Syrian Arab Republic	SY
Bosnia and Herzegovina	BA	Guernsey	GG	Nauru	NR	Taiwan, Province of China	TW
Botswana	BW	Guinea	GN	Nepal	NP	Tajikistan	TJ
Bouvet Island	BV	Guinea-Bissau	GW	Netherlands	NL	Tanzania, United Republic of	TZ
Brazil	BR	Guyana	GY	New Caledonia	NC	Thailand	TH
Britsh I ndian Ocean Territory	IO	Hait	HT	New Zealand	NZ	Timor-Leste	TL
Brunei Darussalam	BN	Heard Island and McDonald Islands	HM	Nicaragua	NI	Togo	TG
Bulgaria	BG	Holy See (Vatcan City State)	VA	Niger	NE	Tokelau	TK
Burkina Faso	BF	Honduras	HN	Nigeria	NG	Tonga	TO
Burundi	BI	Hong Kong	HK	Niue	NU	Trinidad and Tobago	TT
Cabo Verde	CV	Hungary	HU	Norfolk Island	NF	Tunisia	TN
Cambodia	KH	Iceland	IS	Northern Mariana Islands	MP	Turkey	TR
Cameroon	CM	India	IN	Norway	NO	Turkmenistan	TM
Canada	CA	Indonesia	ID	Oman	OM	Turks and Caicos Islands	TC
Cayman Islands	KY	Iran, Islamic Republic of	IR	Pakistan	PK	Tuvalu	TV
Central African Republic	CF	Iraq	IQ	Palau	PW	Uganda	UG
Chad	TD	Ireland	IE	Palestne, State of	PS	Ukraine	UA
Chile	CL	Isle of Man	IM	Panama	PA	United Arab Emirates	AE
China	CN	Israel	IL	Papua New Guinea	PG	United Kingdom	GB
Christmas Island	CX	Italy	IT	Paraguay	PY	United States	US
Cocos (Keeling) Islands	CC	Jamaica	JM	Peru	PE	United States Minor Outlying Islands	UM
Colombia	CO	Japan	JP	Philippines	PH	Uruguay	UY
Comoros	KM	Jersey	JE	Pitcairn	PN	Uzbekistan	UZ
Congo	CG	Jordan	JO	Poland	PL	Vanuatu	VU
Congo, the Democratc Republic of the	CD	Kazakhstan	KZ	Portugal	PT	Venezuela, Bolivarian Republic of	VE
Cook Islands	CK	Kenya	KE	Puerto Rico	PR	Viet Nam	VN
Costa Rica	CR	Kiribat	KI	尅t 惱	QA	Virgin Islands, 簫itsh	VG
Cote d'Ivoire !Côte d'Ivoire	CI	Korea, Democrat c People's Republic of	KP	Reunion !Réunion	RE	Virgin Islands, U.S.	VI
Croata	HR	Korea, Republic of	KR	Romania	RO	Wallis and Futuna	WF
Cuba	CU	Kuwait	KW	Russian Federaton	RU	Western Sahara	EH
Curacao !Curaçao	CW	Kyrgyzstan	KG	Rwanda	RW	Yemen	YE
Cyprus	CY	Lao People's Democrat c Republic	LA	Saint Barthelemy !Saint Barthélemy	BL	Zambia	ZM
Czech Republic	CZ	Latvia	LV	Saint Helena, Ascension and Tristan da Cunha	SH	Zimbabwe	ZW
Denmark	DK	Lebanon	LB	Saint Kits and Nevis	KN		
Djibout	DJ	Lesotho	LS	Saint Lucia	LC		
Dominica	DM	Liberia	LR	Saint Martn (French part)	MF		

Annexure A1

CENTRAL KYC REGISTRY | Know Your Customer (KYC) Application Form | Individual | Correspondence / Local Address

Important Instructions:

A) Fields marked with '*' are mandatory fields.

B) Please fill the form in English and in BLOCK letters.

C) Please fill the date in DD-MM-YYYY format.

D) Please read section wise detailed guidelines / instructions at the end.

E) List of State / U.T code as per Indian Motor Vehicle Act, 1988 is available at the end.

F) List of two character ISO 3166 country codes is available at the end.

G) KYC number of applicant is mandatory for update application.

H) For particular section update, please tick (✓) in the box available before the section number and strike off the sections not required to be updated.

For office use only
(To be filled by financial institution)

Application Type* ☐ New ☐ Update

KYC Number *(Mandatory for KYC update request)*

☐ 1. CORRESPONDENCE / LOCAL ADDRESS DETAILS (Please see instruction **E** at the end)

☐ Same as Current / Permanent / Overseas Address details

Line 1*

Line 2

Line 3 City / Town / Village*

District* Pin / Post Code* State / U.T Code* ISO 3166 Country Code*

☐ 2. CONTACT DETAILS (All communications will be sent on provided Mobile no./ Email-ID) (Please refer instruction **F** at the end) el. (Off)

T – Tel. (Res) – Mobile –

FAX – Email ID

3. APPLICANT DECLARATION

- I hereby declare that the details furnished above are true and correct to the best of my knowledge and belief and I undertake to inform you of any changes therein, immediately. In case any of the above information is found to be false or untrue or misleading or misrepresenting, I am aware that I may be held liable for it.

Date : D D – M M – Y Y Y Y

Place :

[Signature / Thumb Impression]

Signature / Thumb Impression of Applicant

Annexure B1

CENTRAL KYC REGISTRY | Know Your Customer (KYC) Application Form | Individual | Related Person

Important Instructions:

A) Fields marked with '*' are mandatory fields.
B) Please fill the form in English and in BLOCK letters.
C) Please fill the date in DD-MM-YYYY format.
D) Please read section wise detailed guidelines / instructions at the end.
E) List of State / U.T code as per Indian Motor Vehicle Act, 1988 is available at the end.
F) List of two character ISO 3166 country codes is available at the end.
G) KYC number of applicant is mandatory for update application.
H) For particular section update, please tick (✓) in the box available before the section number and strike of the sections not required to be updated.

For office use only *(To be filled by financial institution)* Application Type* ☐ New ☐ Update
KYC Number *(Mandatory for KYC update request)*

☐ 1. DETAILS OF RELATED PERSON (Please refer instruction G at the end)

☐ Addition of Related Person ☐ Deletion of Related Person KYC Number of Related Person (if available*) Type*

Related Person ☐ Guardian of Minor ☐ Assignee ☐ Authorized Representative

Name* Prefix First Name Middle Name Last Name

(If KYC number and name are provided, below details of section 1 are optional)

PROOF OF IDENTITY (PoI) OF RELATED PERSON* (Please see instruction (**H**) at the end)

☐ A- Passport Number Passport Expiry Date D D – M M – Y Y Y Y
☐ B- Voter ID Card
☐ C- PAN Card
☐ D- Driving Licence Driving Licence Expiry Date D D – M M – Y Y Y Y
☐ E- UID (Aadhaar)
☐ F- NREGA Job Card
☐ Z- Others (any document notified by the central government) Identification Number
☐ S- Simplified Measures Account - Document Type code Identification Number

2. APPLICANT DECLARATION

- I hereby declare that the details furnished above are true and correct to the best of my knowledge and belief and I undertake to inform you of any changes therein, immediately. In case any of the above information is found to be false or untrue or misleading or misrepresenting, I am aware that I may be held liable for it.

Date : D D – M M – Y Y Y Y Place :

[Signature / Thumb Impression]

Signature / Thumb Impression of Applicant

3. ATTESTATION / FOR OFFICE USE ONL Y

Documents Received ☐ Certified Copies

KYC VERIFICATION CARRIED OUT BY

Date D D – M M – Y Y Y Y
Emp. Name
Emp. Code
Emp. Designation
Emp. Branch

[Employee Signature]

INSTITUTION DETAILS

Name
Code

[Institution Stamp]

ICICI Lombard
Nibhaye Vaade

Mailing Address: ICICI Lombard Healthcare, ICICI Bank Tower, Plot No. 12, Financial District, Nanakram Guda, Gachibowli, Hyderabad-500032
Registered Office Address: ICICI Lombard House, 414, Veer Savarkar Marg, Near Siddhi Vinayak Temple, Prabhadevi, Mumbai 400 025.
Visit us at: www.icicilombard.com. • **E-Mail us at:** ihealthcare@icicilombard.com. • **Toll Free Number:** 1800 2666. • **Toll Free Fax Number:** 1800-209-8880
IRDA Registration No. 115

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