

ICICI Lombard Health Care Claim Form - Hospitalisation

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



| | Part A | To be filled | Requirement |
|-----------|--|---------------------------|--|
| A1 | Type of Claim- To be filled by Insured | | |
| A2 | Details of the insured person-To be filled by Insured | | |
| A3 | Available in Policy Copy/ Employee details | | |
| A4 | Available in Policy Copy | | |
| A5 | Available in Discharge Summary | By insured/ insured | To track the policy and |
| A6 | Other policy coverages | relatives | other details of the insured |
| A7 | Currently covered by any other mediclaim | | |
| A8 | Available in Hospital Bills/ Self Declaration | | |
| A9 | Available in Hospital Bills | | |
| A10 | Checklist | | |
| A11 | Reason of delay-To be filled by Insured | | |
| Page end | Self declaration | | |
| | Part B | | |
| B1 | Hospital Details | | |
| B2 | Doctor Details | To be filled by Hospital/ | To track the hospital |
| B3 | Patient details | Treating doctor | details and the treatment |
| B4 | Treatment / Procedure Details | | details related to the |
| B5 | Required only for Retail/ Individual Customers | | patient admission |
| Page end | Hospital declaration | | |
| | Part C | | |
| C1 | EFT Details | | y of passbook or bank statemen Iders name and IFSC code |
| C-KYC No. | (Only for Retail/ Individual customers for all claims) | | |
| Yes | Please provide, if Central KYC (C-KYC) no. available: | To be filled by Insured | As per IRDA, C-KYC is manda for for all claims |
| | | | |
| No | Please fill the C-KYC form | | |

| | Documents Submitted | | | |
|-------|--|-----|----|------------------|
| S.No. | Document | Yes | No | Type of document |
| 1. | Claim form duly filled | Y | N | Original |
| 2. | Discharge Summary/ Daycare Summary | Y | N | Original |
| 3. | ICICI Lombard Health card | Y | N | Original |
| 4. | Final Hospital Bill | Y | N | Original |
| 5. | Payment Receipts | Y | N | Original |
| 6. | Investigation Reports | Y | N | Original |
| 7. | Pharmacy Bills | Y | N | Original |
| 8. | Implant Sticker/ Invoice | Y | N | Original |
| 9. | EFT (Copy of cancelled cheque/Copy of passbook or bank statement with | Y | N | Photocopy |
| | Payee/account holders name and IFSC code) | | | |
| 10 | Consultation Paper | Y | N | Photocopy |
| 11. | Age Proof | Y | N | Photocopy |
| 12. | Indoor Case Paper | Y | N | Photocopy |
| 13. | Doctor Prescriptions | Y | N | Photocopy |
| 14. | C-KYC Form (Only for Retail/ Individual customers for all claims) | Y | N | Original |
| 15. | PAN Card Copy of the Proposer/ Employee (Mandatory if claim amount is greater than 1 lakh) | Y | | Photocopy |



Mailing Address: ICICI Lombard Healthcare, Varun Tower II, 1st, 4th, 5th & 6th Floor, Begumpet, Hyderabad, Telangana, Pincode – 500016. 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

| | re Claim Form - Hospitalisation not to be taken as an admission of liability) |
|--|--|
| | |
| Xon-submission of bills and receipts is the main reaso To receive update on your claim status, provide your n | on for delay in claim settlements. Please provide the mandatory documents |
| | e/WhatsApp App or by visiting our website at www.icicilombard.com $ ightarrow$ Claims $ ightarrow$ |
| Health Claims | |
| TO BE FILLED IN CAPITAL LETTERS ONLY | be filled by Insured) |
| A1. Type of Claim : Main Hospitalisation Expenses Pre & Post | Hospitalisation Expenses Cashless Obtained: Yes No |
| A2. Details of the Insured person in respect of whom claim is made | : (patient details) |
| Name of the Patient: | |
| Card No./ UHID of the Patient: | |
| | DD/MM/YWY Completed age: Years Months |
| Occupation: Service Self Employed Homemaker Stud | |
| Are you previously covered by any other Mediclaim/ Health Insura | ance:YesNo If yes, Company name: |
| Current residential address: | |
| | |
| | |
| State: | Image: |
| | |
| E-mail: | |
| ABHA is a 14 digit number that will uniquely identify you as a partic | cinant in India's digital healthcare ecosystem |
| A3. For Group/Corporate Policy | For Individual/Retail Policy (*Mandatory) |
| Member ID No./ Employee ID (Client ID): | *Claim Intimation Service Request no.: |
| | Is this a renewal policy: Yes No |
| Group/Company name: | If Yes, kindly mention your previous policy no.: |
| | |
| A4. Name of the Proposer/Employee: | |
| Relationship with Proposer*: | (*Policy Holder. For Retail policy, Proposer name required. For Corporate policy, provide Employee name) |
| Current Policy No.: | Card No./ UHID: |
| A5. Diagnosis as per discharge summary: | |
| Name of hospital where admitted: | |
| | n sharing 3 or more beds per room Others |
| | M M Date of Discharge: D D / M M / Y Y Y Y Time: H H : M M |
| Date of injury sustained or disease/ Illness first detected: | |
| If Injury, give cause: Self inflicted Road traffic accident Sub | |
| | MLC Report & Police FIR attached: Yes No (If yes, attach report) |
| System of Medicine:] Allopathy] AYUSH | |
| | sident? Yes No If yes, provide AL/Claim No |
| A6. Are you covered under any Topup/Additional policy : Yes No_ | |
| | Date of commencement of first Insurance without break: |
| | ract: Y Date: DD/MM/YYYY Dignosis: |
| | ached bills with any other Insurance company: If yes, attach settlement letter, |
| | Sum Insured: ₹ |
| A8. Details of Claim | |
| a) Details of the treatment expenses claimed | |
| i. Pre-hospitalization expenses: ₹ | ii. Hospitalization expenses: ₹ |
| iii. Post-hospitalization expenses: ₹ | iv. Health-check up cost: ₹ |
| v. Ambulance charges: ₹ | vi. Others: ₹ |
| | Total: ₹ |
| vii. Pre-hospitalization period Days | viii. Post-hospitalization period: |
| b) Claim for | |
| i. Domiciliary Hospitalization: Yes 🔄 No 🔜 ii. Day care: ` | Yes $_$ No $_$ iii. Extended care/ Inpatient rehabilitation: Yes $_$ No $_$ |

c) Details of Lump Sum/ Cash Benefit claimed:

- i. Hospital daily cash:
- iii. Critical illness/PA/Donor Expenses:
- v. Pre/ Post hospitalization lump sum benefit: ₹

| | | | | ii. | Maternity: |
|---|---|---|---|-----|----------------|
| J | J | J | J | iv. | Convalescence: |

₹_____

. Others:

| ₹ | | | | |
|---|--------|--|----|--|
| ₹ | | | | |
| ₹ | \Box | |]_ | |

A9. Details of the amount claimed

| Bill heads (as applicable)Bill numberBill dateBill statchedAmountRoom rentCOMMYYYYN₹Doctors consultation/Visit chargesCOMMYYYYN₹Investigation charges (Includes Radiology and Pathology reports)COMMYYYYN₹Surgeon and Asst. surgeon chargesCOMMYYYYN₹Anesthetist charges & Operation theatre chargesCOMMYYYYN₹Equipment charges/Procedure chargesCOMMYYYYN₹Cost of implant (If any)COMMYYYYN₹Medicine charges & Pharmacy chargesCOMMYYYYN₹Taxes/Surcharges/ServiceCOMMYYYYN₹Discount provided by Hospital/Miscellaneous chargesCOMMYYYYN₹Other TPA/Insurance settled amountCOMMYYYYN₹Pre hospitalization bills & Post hospitalization bills (If any)COMMYYYN₹Total claimed amount (In ₹) (Total claimed amount should be equal to the amount in attached bill documents)₹ | | | | | |
|--|---|-----------------------------|-------------|----------------|--------|
| Doctors consultation/Visit charges Image: Consultation/Visit charges Imag | Bill heads (as applicable) | Bill number | Bill date | Bills attached | Amount |
| Investigation charges (Includes Radiology and Pathology reports) Image: Constant of the second | Room rent | | DDMMYY | Y N | ₹ |
| Surgeon and Asst. surgeon charges D M Y Y N ₹ Anesthetist charges & Operation theatre charges D M Y Y N ₹ Equipment charges/Procedure charges D M Y Y N ₹ Cost of implant (If any) D M Y Y N ₹ Medicine charges & Pharmacy charges D M Y Y N ₹ Taxes/Surcharges/Service D M Y Y N ₹ | Doctors consultation/ Visit charges | | DDMMYY | Y N | ₹ |
| Anesthetist charges & Operation theatre charges D M Y N ₹ Equipment charges/Procedure charges D M Y N ₹ 1 Cost of implant (If any) D M Y N ₹ 1 Medicine charges & Pharmacy charges D M Y N ₹ 1 Taxes/Surcharges/Service D M Y Y N ₹ 1 Discount provided by Hospital/Miscellaneous charges D M Y Y N ₹ 1 Other TPA/Insurance settled amount D M Y Y N ₹ 1 Pre hospitalization bills & Post hospitalization bills (If any) D M Y N ₹ 1 | Investigation charges (Includes Radiology and Pathology reports) | | | Y N | ₹ |
| Equipment charges/ Procedure charges DOMMYYYNN ₹ Cost of implant (If any) DOMMYYYNN ₹ Medicine charges & Pharmacy charges DOMMYYYYNN ₹ Taxes/Surcharges/Service DOMMYYYYNN ₹ Discount provided by Hospital/Miscellaneous charges DOMMYYYYNN ₹ Other TPA/Insurance settled amount DOMMYYYYNN ₹ Pre hospitalization bills & Post hospitalization bills (If any) DOMMYYYYNN ₹ | Surgeon and Asst. surgeon charges | | DDMMYY | Y N | ₹ |
| Cost of implant (If any) □ ○ M M Y Y Y N ₹ Medicine charges & Pharmacy charges □ ○ M M Y Y Y N ₹ Taxes/Surcharges/Service □ ○ M M Y Y Y N ₹ Discount provided by Hospital/Miscellaneous charges □ ○ M M Y Y Y N ₹ Other TPA/Insurance settled amount □ ○ M M Y Y Y N ₹ Pre hospitalization bills & Post hospitalization bills (If any) □ ○ M M Y Y Y N ₹ | Anesthetist charges & Operation theatre charges | | DDMMYY | Y N | ₹ |
| Medicine charges & Pharmacy charges DOMMYYYYN ₹ Taxes/Surcharges/Service DOMMYYYYN ₹ Discount provided by Hospital/Miscellaneous charges DOMMYYYYN ₹ Other TPA/Insurance settled amount DOMMYYYYN ₹ Pre hospitalization bills & Post hospitalization bills (If any) DOMMYYYYN ₹ | Equipment charges/ Procedure charges | | DDMMYY | Y N | ₹ |
| Taxes/Surcharges/Service D M M Y Y Y M ₹ Discount provided by Hospital/Miscellaneous charges D M M Y Y Y M ₹ Other TPA/Insurance settled amount D M M Y Y Y M ₹ Pre hospitalization bills & Post hospitalization bills (If any) D M M Y Y Y M ₹ | Cost of implant (If any) | | DDMMYY | Y N | ₹ |
| Discount provided by Hospital/Miscellaneous charges DOMMYYYN ₹ Other TPA/Insurance settled amount DOMMYYYYN ₹ Pre hospitalization bills & Post hospitalization bills (If any) DOMMYYYYN ₹ | Medicine charges & Pharmacy charges | | | Y N | ₹ |
| Other TPA/Insurance settled amount DOM MYYY ₹ Pre hospitalization bills & Post hospitalization bills (If any) DOM MYYY ₹ | | | D D M M Y Y | Y N | ₹ |
| Pre hospitalization bills & Post hospitalization bills (If any) | Discount provided by Hospital/Miscellaneous charges | | | Y N | ₹ |
| | Other TPA/Insurance settled amount | | DDMMYY | Y N | ₹ |
| Total claimed amount (In ₹) (Total claimed amount should be equal to the amount in attached bill documents) | Pre hospitalization bills & Post hospitalization bills (If any) | | | Y N | ₹ |
| | Total claimed amount (In \mathfrak{T}) (Total claimed amount should be equal to the am | nount in attached bill docu | iments) | | ₹ |

Mandatory: All claim settlements should be made through NEFT(AS per regulatory norms) Please provide your bank account details along with Copy of cancelled cheque/Copy of passbook or bank statement with Payee/account holders name and IFSC code.)

A10. In support of the above claim, I enclose following documents in original (Please indicate by ticking in the Yes/ No column below)

| Type of Document(s) - *Mandatory | Yes | No | Type of Document(s) - As Applicable | Yes | No |
|--|-----|----|--|-----|----|
| 1. Claim form duly filled and signed* | Y | N | 9. ICICI Lombard GIC Authorisation Letter | Y | N |
| 2. Cancelled cheque (for bank account details) | Y | Ν | 10. Implant name and invoice (if any) with implant sticker | Y | N |
| 3. Discharge summary* | Y | N | 11. Indoor Case Papers | Y | N |
| 4. Hospital bills, Final/ Main hospital bill and other bills (if any)* | Y | Ν | 12. Prescription papers/ Consultation papers | Y | Ν |
| 5. Hospital payment receipt & other receipts supporting bills* | Y | Ν | 13. C-KYC FORM (Only for Retail/Individual customers for all claims) | Y | N |
| 6. Investigation reports* (Including ECG/ CT/ MRI/ USG/ HPE) | Y | N | 14. Others (details) | Y | Ν |
| 7. Medicine/ Pharmacy bills with doctors prescription* | Y | Ν | | | |
| 8. Age proof (Driving License/ PAN card/ Passport) | Y | Ν | | | |

Kindly do not furnish Aadhaar card and send any other document for id proof

Please attach all the documents as per above serial number. Films like x-ray film, CT Scan film, MRI Scan film, etc. are not required. Provide reports only

A11.Please provide the reason for delay in submitting the documents

(Post 30 days from Date of Discharge)

Declaration by the Insured:

I hereby declare that the information furnished in this claim form is true and correct to the best of my knowledge and belief. If I have made any false or untrue statement, suppression or concealment of any material fact with respect to questions asked in relation to this claim, my right to claim reimbursement shall be forfeited. I also consent and authorize TPA/ insurance company, to seek necessary medical information/ documents from any hospital/ Medical Practitioner who has attended on the person against whom this claim is made. I hereby declare that I have included all the bills/ receipts for the purpose of this claim and that I will not be making any supplementary claim except the pre/ post-hospitalization claim, if any. I hereby give my consent to the Company to verify my identity through Central KYC Registry or UIDAI or through any other modes for the purpose of undertaking KYC.

Date: DD/MM/YYY

Place:

Insured's Signature:

क्लेम फॉर्म हिन्दी के लिए क्रपया हमारी वेबसाइट पर जाँच कीजिए : www.icicilombard.com

Claim documents to be dispatched to: ICICI Lombard Healthcare, Varun Tower II, 1st, 4th, 5th & 6th Floor, Begumpet, Hyderabad, Telangana, Pincode – 500016.

In case the policy is serviced by external TPA, please dispatch the claim documents to respective TPAs.

▲ Your Claim details are just an SMS away, Please SMS <KEYWORD> to 57 57 58

• Cashless Status: <KEYWORD> is "ILHC AL <12-digit-AL-No.>" • Claim Status: <KEYWORD> is "ILHC CL <12-digit-CL-No.>" • Payment details: <KEYWORD> is "ILHC PAY <12-digit-Claim-No.>"

(AL No. & CL No. is the one you have received on your mobile no. after intimating us)

| lo ho tillod hi | / Footing | I Dootor/ Hoo | nitol only |
|------------------|-----------|----------------|------------|
| | | 1 0.004007 608 | |
| (To be filled by | | | |

| Tall - D (To be timed by freading bo | ictor/ nospital only/ | | | | |
|--|---|--|--|--|--|
| B1. Details of the Hospital/Nursing homein which treatment was taken | | | | | |
| Name of the Hospital/Nursing home: | | | | | |
| Address: | | | | | |
| City: | | | | | |
| Pincode: | | | | | |
| ROHINI ID*: | | | | | |
| Registration No. with State Code: PAN: | Number of Inpatient beds: | | | | |
| Facilities available in the hospital: OT: <u>V</u> ICU: <u>V</u> N R2. *Details of the extending Medical Prestitionary (Dectar) (Treating Physician | | | | | |
| B2. *Details of the attending Medical Practitioner/ Doctor/ Treating Physician | or Surgeon | | | | |
| | | | | | |
| Qualification: | | | | | |
| Telephone no.: | | | | | |
| B3. Details of the patient admitted | | | | | |
| Name of the patient: | | | | | |
| IP Registration no.: Age: Gender: M_F Age: | Years Months Date of Birth: DDMMYYYY | | | | |
| Date of Admission: DD/MM/YYY Time: HHMM Date of Di | ischarge: DD/MM/YYYY Time: HH:MM | | | | |
| Type of Admission: Emergency Planned Day Care | Maternity | | | | |
| Type of Treatment: Surgical Procedure 🔄 Multiple Surgical Procedure 📃 Medi | cal Treatment | | | | |
| If Maternity, Date of Delivery: DD/MM/YYYY Gravida Status | | | | | |
| Premature Baby: Yes No | | | | | |
| Status at time of discharge: Discharge to home Discharge to another hospita | I Deceased | | | | |
| Total claimed amount: ₹ | | | | | |
| B4. Details of the procedure | | | | | |
| Pre-authorization obtained: Yes No If yes, Pre-authorization No.: | | | | | |
| If authorization by network hospital not obtained, give reason: | | | | | |
| Date of injury sustained or disease/illness first detected: DD/MM/YYY | Y | | | | |
| | se/Alcohol consumption Others | | | | |
| If Medico legal: Yes No Reported to police: Yes No MLC Report & Police | • | | | | |
| FIR no If not reported to Police, give reason: | | | | | |
| If injury due to substance abuse/alcohol consumption, test conducted to establish this | : Yes No (If yes attach report) | | | | |
| | | | | | |
| B5. This section is mandatory only if your health policy is not provided by your | employer | | | | |
| A) Diagnosis (ICD 10 Code primary & additional dignosis) | | | | | |
| i) Primary diagnosis (with ICD 10 code) | | | | | |
| ii) Additional diagnosis (with ICD 10 code) | | | | | |
| iii) Procedure diagnosis (with ICD 10 PCS code) B) Nature of surgery/ treatment given for present ailment | | | | | |
| C) Date of first consultation (Prior to hospitalization) | | | | | |
| D) Presenting complaints of the patient during admission | | | | | |
| E) Past medical history of the patient along with duration of illness | | | | | |
| (If yes, attach first & all past consultation paper) | | | | | |
| F) Was the patient under influence of alcohol during admission | | | | | |
| G) Whether the present treatment ailment is a complication of pre-existing disease ? | | | | | |
| i) If yes, please specify the disease (or) complication of any previous surgery done? | | | | | |
| ii) If yes, please specify the details | | | | | |
| H) Whether the disease/ disorder is congenital in nature? | | | | | |
| I) Number of in-patient beds in the hospital (including ICU) | | | | | |

Declaration by the hospital*

We hereby declare that the information furnished in this Claim Form is true & correct to the best of our knowledge and belief. If we have made any false or untrue statement, suppression or concealment of any material fact, our right to claim under this claim shall be forfeited.

Registration No. of Hospital

(Rubber stamp of the hospital)

Date: DD/MM/YYYY

Doctor's Seal and Signature

As per the policy Terms and Conditions, the Company reserves its right to have the Insured examined by a doctor appointed by it for verification of diagnosis.

| 6 | Part - C - NEFT Form Nibhaye Vaade (For Direct Electronic Fund Transfer) |
|-------------|--|
| • | Mandatory: All claim settlements should be made through NEFT(as per regulatory norms) Please provide your bank account details along with Copy of Cancelled cheque,Copy of passbook or bank statement with Payee/account holders name and IFSC code.) Kindly provide your consent to validate your bank account details with ₹1 credit for claim processing in your account as per below grid. To be added along with Mandatory NEFT info. |
| C1. | Patient's Name: |
| C2. | PAN No. of the Proposer (Mandatory if claim amount is greater than 1 lakh) |
| C3. | |
| C4. | Claim Number (if allotted): |
| C5. | Mobile/ Contact No.: |
| | Email: |
| C7 . | 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. |
| Ple | ase provide 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 |
| C 8. | Please provide the below details (all fields are compulsory) |
| | Proposer (Policy holder)/ Employee name*(as per bank |
| | records): |
| | Proposer/ Policy holder Bank accou |
| | Name of the bank: |
| | Branch name: |
| | Address of the bank: |
| | IFSC code no. of the bank: IFSC code no. of the bank: |
| *Pr | poser/ 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. |
| Term | s 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 |
| 4. | Insurance Company Limited. 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. |
| 5. | arising from or in connection with, amongst other things, either of the aforesaid reasons stated in above clauses. 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 |
| 6. | 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. 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 |
| 7. | holder. 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 |
| 8. | holder only. 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. 10. | 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. 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 |
| 11. | the last address of the Proposer/policy holder. 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 or 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.

| | 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 for all claims. | | | | | | | | |
| To be filled by Proposer: | KYC Number (Mandatory for KYC update request) If KYC Number is not available, please fill this Central-KYC (C-KYC) form | | | | | | | |
| 1. PERSONAL DETAIL | ILS | | | | | | | |
| | Prefix First Name Middle Name Last Name | | | | | | | |
| □ Name* (Same as ID proof) | | | | | | | | |
| Maiden Name (If any*) | | | | | | | | |
| Father / Spouse Name* | | | | | | | | |
| Mother Name* | | | | | | | | |
| Date of Birth* Gender* | | | | | | | | |
| Gender | M- Male F- Female Transgender | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| _ | | | | | | | | |
| | ITY (PoI)* (Please refer instruction C at the end) | | | | | | | |
| | ne following Proof of Identity[Pol] needs to be submitted) | | | | | | | |
| A- Passport Number | Passport Expiry Date | | | | | | | |
| B- Voter ID Card C- PAN Card | | | | | | | | |
| D- Driving Licence | | | | | | | | |
| E- UID (Aadhaar^) | Driving Licence Expiry Date D M Y Y | | | | | | | |
| F- NREGA Job Card | | | | | | | | |
| | ent notified by the central government) | | | | | | | |
| | s Account - Document Type code | | | | | | | |
| . 3. PROOF OF ADDRE | •• | | | | | | | |
| | OVERSEAS ADDRESS DETAILS (Please see instruction D at the end) | | | | | | | |
| | ne following Proof of Address [PoA] needs to be submitted) | | | | | | | |
| Address Type* | esidential / Business | ified | | | | | | |
| | assport | | | | | | | |
| | bter Identity Card INREGA Job Card Others Identity Card Decument Time and | | | | | | | |
| Address | implified Measures Account - Document Type code | | | | | | | |
| Line 1* | | | | | | | | |
| Line 2 | | | | | | | | |
| Line 3 District* | Pin / Post Code* State / U.T Code* ISO 3166 Country Code* | | | | | | | |
| | | | | | | | | |
| ^ Mask first 8 digits of your aadhaa | aar number in claim form and claim documents submitted. | | | | | | | |

Account Holder's Signature



Mailing Address: ICICI Lombard Healthcare, Varun Tower II, 1st, 4th, 5th & 6th Floor, Begumpet, Hyderabad, Telangana, Pincode – 500016.
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