

ICICI Lombard Health Care Claim Form - Hospitalisation

ICICI Lombard Health Care

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

	Overview Health Claim Forr	m - Hospitalization			
	Part A	To be filled	Requirement		
A1	Self Declaration				
A2	Self Declaration				
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	Self Declaration	relatives	other details of the insured		
A7	Self Declaration				
A8	Available in Hospital Bills/ Self Declaration				
A9	Available in Hospital Bills				
A10	Checklist				
A11	Self declaration				
A12	ETF details				
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				
C-KYC No.	Part C (Only for Retail/ Individual customers if claiming >₹ 1	l lakh)			
Yes	Please provide, if Central KYC (C-KYC) no. available:	T 1 (" 11 1	As per IRDA, C-KYC is mandate		
		To be filled by Insured	for claims greater than ₹ 1 lakh		
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.	Final Hospital Bill	Y	N	Original	
4.	Payment Receipts	Y	N	Original	
5.	Investigation Reports	Y	N	Original	
6.	Pharmacy Bills	Y	N	Original	
7.	Implant Sticker/ Invoice	Y	N	Original	
8.	Doctor Prescriptions	Y	N	Photocopy	
9.	Consultation Paper	Y	N	Photocopy	
10.	Age Proof	Y	N	Photocopy	
11.	Indoor Case Paper	Y	N	Photocopy	
12.	EFT (Copy of cancelled cheque/ self attested ID poof/ Bank attested copy	V 1	N	Dhotocony	
	of passbook with IFSC code	Y	11/	Photocopy	
13.	Part D - C-KYC Form (Only for Retail/ Individual customers if claiming >₹ 1 lakh)	Υ	N	Original	
14.	Mask first 8 digits of your Aadhaar Card ^ Copy of the Proposer/ Employee	Y		Photocopy	
15.	PAN Card Copy of the Proposer/ Employee (Mandatory)	<u>Y</u>]		Photocopy	

[^] Mask first 8 digits of your aadhaar number in claim form and claim documents submitted.





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ALL CLAIM SETTLEMENTS SHOULD BE MADE THROUGH NEFT (AS PER IRDA CIRCULAR).

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
- ★ You can track your claim status at: www.icicilombard.com→Claims→Health Claims→Services→Track your claims

Part - A (10 b	e filled by insured)
TO BE FILLED IN CAPITAL LETTERS ONLY A1. Type of Claim: Main Hospitalisation Expenses Pre & Post H	ospitalisation Expenses Cashless Obtained: Yes No
A2. Details of the Insured person in respect of whom claim is made:	
Name of the Patient:	"MIDDLE LAST
Card No./ UHID of the Patient:	
Gender: Male Female Transgender Date of Birth:	DD/MM/YYYY Completed age: Years Months
Occupation: Service Self Employed Homemaker Stude	ent Retired Other (Please specify)
Are you previously covered by any other Mediclaim/ Health Insura	nce:Yes No
Current residential address:	
	City:
State:	Pin code:
Mobile noLandline no	
E-mail:	
	ccination Covishield Covaxin Sputnik Others
Dosage of Vaccination: 1st Dose 2nd Dose 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.:
droup/ company name.	In res, 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. Nature of disease/illness contracted or injury suffered for which	h Insured was hospitalized (Diagnosis):
Name of hospital where admitted:	
Room category occupied: Day care Single occupancy Twin	sharing 3 or more beds per room Others
Date of Admission: DD/MM/YYYY Time:	Date of Discharge: DD/MM/YYYY Time: HH:MM
Date of injury sustained or disease/ Illness first detected: DD D / M	M/YYYY
If Injury, give cause: Self inflicted Road traffic accident Subs	tance abuse/ Alcohol consumption Others
If Medico legal: Yes No Reported to police: Yes No N	ILC Report & Police FIR attached: Yes No (If yes, attach report)
System of Medicine:	
	dent? 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:
Have you been hospitalized in the last 4 years since inception of contra	
Have you lodged any claim against this particular admission date/ atta	ched bills with any other Insurance company: If yes, attach settlement letter,
Company name: Policy No.	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: ₹	: ₹
vii Pro hoopitalization period	Total: ₹
vii. Pre-hospitalization period Days	viii. Post-hospitalization period: Days
b) Claim for	M- m-e, 1
i. Domiciliary hospitalization: Yes INO II. Day care: Ye	es $_$ No $_$ iii. Extended care/ Inpatient rehabilitation: Yes $_$ No $_$

i. Hospital daily cash: ₹	_]_]_]_	ii	. Maternity:	₹			J
iii. Critical illness/PA/Donor Expenses: ₹	_]_]_]_	iv	. Convalescence:	₹			J
v. Pre/ Post hospitalization lump sum benefit: ₹			v	i. Others:	₹			
A9. Details of the amount claimed					-			,
Bill heads (as applicable)		Ri	II number	Bill date	Bills attached	Δn	nount	
Room rent			ii iiuiiiboi		y N	₹]		1 1
Doctors consultation/ Visit charges					Y	₹]]		<u></u>
Investigation charges (Includes Radiology and Pathology reports	3)			D D M M Y Y	Y	₹]]	<u>/</u>	<u> </u>
Surgeon and Asst. surgeon charges	-1				Y N	₹]]	<u>/</u>	
Anesthetist charges & Operation theatre charges					YN	₹]]	<u>/</u>	<u>ر ر ر</u> ا ا
Equipment charges/ Procedure charges					Y	₹]]		<u></u> _
Cost of implant (If any)					Y	₹]]	<u>/</u>	<u> </u>
Medicine charges & Pharmacy charges						₹]]	<u>/</u>	
Taxes/ Surcharges/ Miscellaneous/Service charge/ Other charge	100/				Y N	()] _	<u>/</u>	الـــــــــــــــــــــــــــــــــــــ
Discount provided by hospital (If any)	jes/			D D M M Y Y	Y N	₹]	
Pre hospitalization bills & Post hospitalization bills (If any)				D D M M Y Y	Y N	₹	<u> </u>	
Total claimed amount (In ₹) (Total claimed amount should be equal to	the amo	ount in a	ttached bill docun	nents)		₹		
A10. In support of the above claim, I enclose following docu	ımant	o in or	iginal (Dlagge	indicate by ticking i	n the Vec/Ne e	aluma halavu)		
			 			olullili below)		
Type of Document(s) - *Mandatory	Yes	No		cument(s) - As App cheque (for bank acco			Yes	N
Claim form duly filled and signed* Discharge summary*		N		bard GIC Authorisation				
Hospital bills, Final/ main hospital bill and other bills (if any)*	V	N		name and invoice (if an		ricker		
Hospital bills, Filial, frial flospital bill and other bills (if airy) Hospital payment receipt & other receipts supporting bills*	Y	N	11. Indoor Ca		y, with implant of	.iokoi	<u> </u>	1
Investigation reports* (Including ECG/ CT/ MRI/ USG/ HPE)		N		on papers/ Consultation	n naners		V	-
6. Medicine/ Pharmacy bills with doctors prescription*		N	-	IRM (Only for Retail/Indivi		ning < ₹ 11 akh\	<u> </u>	
7. Age proof (Driving License/ PAN card/ Passport/ Aadhaar copy ^)*	: V	N	14. Others (d		audi Customers, Cidin	IIIIy / (ILakii)		1
		1 OT	· · · · · ·	<u> </u>				
Please attach all the documents as per above serial number. Films like				an mm, etc. are not requ	irea. Provide reports	SOTHY		
A11.Please provide the reason for delay in submitting th (Post 30 days from Date of Discharge)	e doc	eumen	ts	Provide I	Details (If Applic	able)		
A12. Please provide the below details (all fields are comp	ulenry	/ \						
-	-	•			1 1 1 1		1 1	
 Proposer (policy holder)/ Employee name*(as per believed) 	oank red	cords).					J_J_	ノ_
 Proposer/ policy holder Bank account no.: 					J_J		J_J_	J_
Name of the bank:							J	
Branch name:								
IFSC code no. of the bank:	1 1) PANIN	No. of the Propose	r.		1 1	
Il 30 code llo. Of the balk.			J_ TANT	vo. or the rropose	·		J_J_	J_
*Please provide a Cancelled cheque of account holder.								
*Proposer/ Policy holder is the person who has paid premiu	m for	the ne	liov					
For Retail policy, Name & Account details of Proposer requi		-	-	Employee Name &	Account details	roquirod		
Tot netall policy, Ivallie a Account details of Froposer requ	ii Gu. i	oi co	iporate policy	, Lilipioyee Ivallie a	Account uctans	s requireu.		
Declaration by the Insured:								
I hereby declare that the information furnished in this claim for								
untrue statement, suppression or concealment of any material								
reimbursement shall be forfeited. I also consent and authoriz								
hospital/ Medical Practitioner who has attended on the per- receipts for the purpose of this claim and that I will not be mak								DIIIS/
1000 pto 101 the purpose of this diditifulia that I will not be mak	y ull	y supp	nomonital y old	iiii oxoopt tiio pie/ pt	ot noopituiizatit	,,, oluli,, ii uliy	•	
				I II O'				
Date: DD/MM/YYYY Place:				Insured's Signatu	ire:			
^ Mask first 8 digits of your aadhaar number in claim form and claim docu								
क्लेम फॉर्म हिन्दी के लिए कर	पया हमा	री वेबसाइ	ट पर जाँच कीजिए	: www.icicilombard.co	m			

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

Claim documents to be dispatched to: ICICI Lombard Healthcare, ICICI Bank Tower, Plot No. 12, Financial District, Nanakram Guda, Gachibowli, Hyderabad, TS-500032

Part - B (To be filled by Treating Doctor/ Hospital only) B1. Details of the Hospital/Nursing home in which treatment was taken Name of the Hospital/Nursing home: Address: City: Pincode: Mobile no .: Telephone no.: ROHINI ID*: Type of Hospital: Network ____ Non Network ____. If Non Network, provide below details Number of Inpatient beds: Registration No. with State Code: Facilities available in the hospital: OT: B2. *Details of the attending Medical Practitioner/ Doctor/ Treating Physician or Surgeon Name: Qualification: Registration no: Telephone no.: Mobile no .: **B3.** Details of the patient admitted Name of the patient: Gender: M F T Age: Years Months Date of Birth: IP Registration no.: Date of Admission: DD/MM/YYYYY Time: HH: MM Date of Discharge: DD / MM / YYYY Time: Type of Admission: Emergency Planned Day Care ____ Maternity___ Multiple Surgical Procedure Medical Treatment Type of Treatment: Surgical Procedure _ D] D] / M] M] / Y] Y] Y] Y] Gravida Status: G P A L If Maternity, Date of Delivery: Premature Baby: Yes No Status at time of discharge: Discharge to home Discharge to another hospital 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//Y If Injury, give cause: Self inflicted Road traffic accident Substance abuse/Alcohol consumption If Medico legal: Yes___ No___ Reported to police: Yes___ No___ MLC Report & Police FIR attached: Yes___ No___ (If yes, attach report) 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) D) Presenting complaints of the patient during admission

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)	

- 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)

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.

- 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.

D) Please read section wise de	etailed guidelines / instructions at the end.		ction update, please tick (\checkmark) in the and strike off the sections not requi	
To be filled by Propose	er: Application Type* ☐ New ☐ Update	е		
	KYC Number		(Mandatory for KYC update	te request)
	If KYC Number is not available, please fill t	this Central-KYC (C-KYC)) form	
☐ 1. PERSONAL DETA	AILS (Please refer instruction A at the end)		
	Prefix First Name		Middle Name	Last Name
☐ Name* (Same as ID pro	of)			
Maiden Name (If any*)				
Father / Spouse Name*				
Mother Name*				
Date of Birth*			_	РНОТО
Gender*	☐ M- Male	☐ F- Female	T-Transgender	
Marital Status*	☐ Married	Unmarried	Others	
Citizenship*	☐ IN- Indian	Others (ISO 310	66 Country Code)	
Residential Status*	☐ Resident Individual☐ Foreign National	☐ Non Resident In☐ Person of Indian		
Occupation Type*	☐ S-Service (☐ Private Sector	☐ Public Sector	☐Government Sector)	
	☐ O-Others (☐ Professional	☐ Self Employed	☐ Retired ☐ Housewife	☐Student)
	☐ B-Business☐ X- Not Categorised			
	<u> </u>			
Z. TICK IF APPLICA	ABLE RESIDENCE FOR TAX PURF	POSES IN JURISDIC	TION(S) OUTSIDE INDIA	(Please refer instruction b at the end)
	REQUIRED* (Mandatory only if section 2 is	sticked)		
·	of Jurisdiction of Residence*			
	r or equivalent (If issued by jurisdiction)*			
Place / City of Birth*		ISO 3166 Country	Code of Birth.	
□3 PPOOF OF IDEN	TITY (Pol)* (Please refer instruction C at	the end)		
_				
	the following Proof of Identity[Pol] needs to	be submitted)	Decement Evening Date	
A- Passport Number			Passport Expiry Date	
B- Voter ID Card				
☐ C- PAN Card				
D- Driving Licence			Driving Licence Expiry Date	• DDD—MM—YYYY
E- UID (Aadhaar^)				
F- NREGA Job Card				
_ ` ` `	ent notified by the central government)		Identification Numbe	
S- Simplified Measure	es Account - Document Type code		Identification Numbe	ŧ۲
4. PROOF OF ADD	RESS (PoA)*			
	ANENT / OVERSEAS ADDRESS DETAILS (•	D at the end)	
(Certified copy of any one of	the following Proof of Address [PoA] needs	to be submitted)		
Address Type*	Residential / Business	ential	Business	stered Office
	•	_	UID (Aadhaar^)	
	Voter Identity Card ☐ NREC Simplified Measures Account - Docum		Others	gase speptry
Address		71		
Line 1*				
Line 2			0:5.77	310 00 \$
Line 3 District*	Pin / Post Code ³	*	State / U.T Code*	ISO 3166 Country Code*
DIGUIOL	Fill / Fost Code		State / O.1 Gode	100 0100 Country Couc

[^] Mask first 8 digits of your aadhaar number in claim form and claim documents submitted.

4.2 CORRESPONDENCE Same as Current / Perma			struction E at the end) iple correspondence / local addresses, please fill 'Annexure A1')	
Line 1* Line 2				
Line 3 District*		Pin / Post Code*	State / U.T Code* ISO 3166 Country Code*	
Same as Current / Perma Line 1* Line 2 Line 3 State*	nent / Overseas Addr	ess details	RESIDENT OUTSIDE INDIA FOR TAX PURPOSES* (Applicable if section 2 is ticked) Same as Correspondence / Local Address details City / Town / Village* ZIP / Post Code* ISO 3166 Country Code*	ed)
Tel. (Off)	(All communications wi	Tel. (Res) Email ID	Mobile	
☐ 6. DETAILS OF RELAT ☐ Addition of Related Person Related Person Type*	ED PERSON (In cas Deletion of Relate	d Person	sons, please fill 'Annexure B1') (please refer instruction G at the end) KYC Number of Related Person (if available*) ee Authorized Representative	
Name*	Prefix (if KYC number an	First Name	Middle Name Last Name u details of section 6 are optional)	
A- Passport Number B- Voter ID Card C- PAN Card D- Driving Licence E- UID (Aadhaar^)	OF RELATED PERSO	N* (Please see instruction (H) a	Passport Expiry Date Driving Licence Expiry Date Driving Licence Expiry Date]
F- NREGA Job Card Z- Others (any documer S- Simplified Measure: 7. REMARKS (If any)	-	ent Type code	Identification Number	
1. REMARKS (II ally)		Niconie 110. 7	./ Email-ID (Please refer instruction F at the end)	
therein, immediately. In case any of for it. I hereby consent to receiving inform Date:	nished above are true and corr the above information is foun nation from Central KYC Regis	d to be false or untrue or misleading or stry through SMS/Email on the above re	belief and I undertake to inform you of any changes or misrepresenting, I am aware that I may be held liable [Signature / Thumb Impression] registered number/email address. Signature / Thumb Impression of Applican	t
	Certified Copies		INSTITUTION DETAILS	
Date Emp. Name Emp. Code Emp. Designation Emp. Branch			Name Code	

 $^{{\}hat{\ }}$ Mask first 8 digits of your aadhaar number in claim form and claim documents submitted.

CENTRAL KYC REGISTRY | Instructions / Checklist / Guidelines for filling Individual KYC Application Form

General Instructions:

- 1 Fields marked with '*' are mandatory fields.
- 2 Tick '✓' wherever applicable.
- 3 Self-Certification of documents is mandatory.
- 4 Please fill the form in English and in BLOCK Letters.
- 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 respectively list of which is available at the end.
- 7 KYC number of applicant is mandatory for updation of KYC details.
- 8 For particular section update, please tick (🗸) in the box available before the section number and strike off the sections not required to be updated.
- 9 In case of 'Small Account type' only personal details at section number 1 and 2, photograph, signature and self-certification required.

A Clarification / Guidelines on filling 'Personal Details' section

- 1 Name: Please state the name with Prefix (Mr/Mrs/Ms/Dr/etc.). The name should match the name as mentioned in the Proof of Identity submitted failing which the application is liable to be rejected.
- 2 Either father's name or spouse's name is to be mandatorily furnished. In case PAN is not available father's name is mandatory.

B Clarification / Guidelines on filling details if applicant residence for tax purposes in jurisdiction(s) outside India

1 Tax identification Number (TIN): TIN need not be reported if it has not been issued by the jurisdiction. However, if the said jurisdiction has issued a high integrity number with an equivalent level of identification (a "Functional equivalent"), the same may be reported. Examples of that type of number for individual include, a social security/insurance number, citizen/personal identification/services code/number, and resident registration number)

C Clarification / Guidelines on filling 'Proof of Identity [Pol]' section

- 1 If driving license number or passport is provided as proof of identity then expiry date is to be mandatorily furnished.
- 2 Mention identification / reference number if 'Z- Others (any document notified by the central government)' is ticked.
- 3 In case of Simplified Measures Accounts for verifying the identity of the applicant, any one of the following documents can also be submitted and undernoted relevant code may be mentioned in point 3 (S).

уı	be membried in point 5 (3).	
	Document Code	Description
	01	Identity card with applicant's photograph issued by Central/ State Government Departments, Statutory/ Regulatory Authorities,
		Public Sector Undertakings, Scheduled Commercial Banks, and Public Financial Institutions.
	02	Letter issued by a gazetted officer, with a duly attested photograph of the person.

D Clarification / Guidelines on filling 'Proof of Address [PoA] - Current / Permanent / Overseas Address details' section

- 1 PoA to be submitted only if the submitted PoI does not have an address or address as per PoI is invalid or not in force.
- 2 State / U.T Code and 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 submitted and undernoted relevant code may be mentioned in point 4.1.

Document Code	Description
01	Utility bill which is not more than two months old of any service provider (electricity, telephone, post-paid mobile phone, piped gas, water bill).
02	Property or Municipal Tax receipt.
03	Bank account or Post Office savings bank account statement.
04	Pension or family pension payment orders (PPOs) issued to retired employees by Government Departments or Public Sector Undertakings, if they contain the address.
05	Letter of allotment of accommodation from employer issued by State or Central Government departments, statutory or regulatory bodies, public sector undertakings, scheduled commercial banks, financial institutions and listed companies. Similarly, leave and license agreements with such employers allotting official accommodation.
06	Documents issued by Government departments of foreign jurisdictions and letter issued by Foreign Embassy or Mission in India.

E Clarification / Guidelines on filling 'Proof of Address [PoA] - Correspondence / Local Address details' section

- 1 To be filled only in case the PoA is not the local address or address where the customer is currently residing. No separate PoA is required to be submitted.
- 2 In case of multiple correspondence / local addresses, Please fill 'Annexure A1'

F Clarification / Guidelines on filling 'Contact details' section

- 1 Please mention two- digit country code and 10 digit mobile number (e.g. for Indian mobile number mention 91-999999999).
- 2 Do not add '0' in the beginning of Mobile number.

G Clarification / Guidelines on filling 'Related Person details' section

1 Provide KYC number of related person if available.

H Clarification / Guidelines on filling 'Related Person details – Proof of Identity [Pol] of Related Person' section

1 Mention identification / reference number if 'Z- Others (any document notified by the central government)' is ticked.

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

State / U.T	Code	State / U.T	
Andaman & Nicobar	AN	Himachal Pradesh	
Andhra Pradesh	AP	Jammu & Kashmir	
Arunachal Pradesh	AR	Jharkhand	
Assam	AS	Karnataka	
Bihar	BR	Kerala	
Chandigarh	CH	Lakshadweep	
Chattisgarh	CG	Madhya Pradesh	
Dadra and Nagar Haveli	DN	Maharashtra	
Daman & Diu	DD	Manipur	
Delhi	DL	Meghalaya	
Goa	GA	Mizoram	
Gujarat	GJ	Nagaland	
Haryana	HR	Orissa	

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

List of ISO 3166 two- digit Country Code

Marchane	Country	Country	Country	Country	Country	Country	Country	Country
Mand Lander		Code		Code		Code		Code
Agent								
Algerina QZ El Sandoris Glosses QZ Marce management MZ Sea Martine MZ Annobrana AS Fasistical Glosses QZ Misception, Use former Nagotive Regulation MX Sont Probable XT Angelia AD El Sanis El Mississes Mississes MX Sont Probable XT Angelia AD El Tolico El Mississes Mississes MX Sont Probable XT Angelia AR Filter Sanish FILT Mallaria MX Sont Received XX Argentinis AR Filter Official FILT Mallaria MI Sont Barrior SECTION XX Australia AR Filter Official FILT Mallaria MI Sont Barrior SECTION XX Australia AR Feminal Official FILT Mallaria MI Sont Barrior SECTION SONT SONT SONT SONT SONT SONT SONT SO								
American								
Agent	Algeria				Luxembourg		San Marino	SM
Mediagnorm	American Samoa	AS	Equatorial Guinea	GQ	Macao	MO	Sao Tome and Principe	ST
Angelita Aj Ethiopia ET Mealawi Mode Seriche (S. Seycheller) CS Antigeria AG Faltendis (Moléries) FX Moléries MV Seriche (S. Seycheller) SC Antigeria AG Farice blanch FX Moléries MV Seriche (S. Seycheller) SC Antigeria AG Farice blanch FR Mearland (S. Marchall Blanch) MV Sorical (S. Marchall Blanch) SC Antigeria Ag French Coulter FR Mearland Blanch MH Soverhal SC Balancia Ag French Southern Territories FT Mearland MU Soverhal SO Balancia Ag German GR Mearland MU Somalia SO Balancia BI German GR Mearland MU Somalia SO Balancia BI German GR Memora MU South Samuel SO Balancia BI German	Andorra	AD	Eritrea			MK	Saudi Arabia	
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	Dominica	DM	Liberia	LR	Saint Martin (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 (\mathcal{J}) in the box available before the section number and strike off the sections not required to be updated.

For office use only	Application Type*	New	Update					
(To be filled by financial institution)	KYC Number					(Mandatory	for KYC update request)	
1. CORRESPONDENCE	LOCAL ADDRESS DE	ETAILS	(Please see in	nstruction E a	at the end)			
☐ Same as Current / Permanent /	Overseas Address details	3						
Line 1*								
Line 2								
Line 3						City / Town /	Village*	
District*	Pin / Po	ost Code	*		State / U.	T Code*	ISO 3166 Country Co	ode*
2. CONTACT DETAILS (All co	mmunications will be sent or	n provided l	Mobile no./ Ema	ail-ID) (Please	refer instru	ction F at the end)	
Tel. (Off)		Tel. (Res)				Mobile		
FAX		Email ID						
3. APPLICANT DECLARA	TION							
I hereby declare that the details furnished al therein, immediately. In case any of the abo		•	-			-		
liable for it.				p		.,		
Date : DD - MM - YY	Y Y Place :						Signature / Thumb Impression of A	Applicant
	<u> </u>							

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 off the sections not required to be updated.

For office use only	Application Type* ☐ New ☐ Upda	ate					
(To be filled by financial insti	tution) KYC Number	(Mandatory for KYC update request)					
1. DETAILS OF RELAT	TED PERSON (Please refer instruction G at the end)						
Addition of Related Person	☐ Deletion of Related Person K	YC Number of Related Person (if available*)					
Related Person Type*	☐ Guardian of Minor ☐ Assignee	Authorized Representative					
	Prefix First Name	Middle Name Last Name					
Name*							
	(If KYC number and name are provided, below details	of section 1 are optional)					
PROOF OF IDENTITY (Po	I) OF RELATED PERSON* (Please see instruction (H) a	at the end)					
☐ A- Passport Number		Passport Expiry Date					
☐ B- Voter ID Card							
C- PAN Card							
☐ D- Driving Licence	Driving Licence Expiry Date DD - MM - Y Y Y Y						
☐ E- UID (Aadhaar^)	Driving Licence Expiry Date D D M M T T T T T						
☐ F- NREGA Job Card							
Z- Others (any document notified by the central government)							
☐ S- Simplified Measure	s Account - Document Type code	Identification Number					
2. APPLICANT DEC							
	mished above are true and correct to the best of my knowledge and bel of the above information is found to be false or untrue or misleading or						
liable for it.		[Signature / Thumb Impression]					
Date : DD - MM -	Y Y Y Y Place:	Signature / Thumb Impression of Applicant					
3. ATTESTATION / FO	R OFFICE USE ONL Y						
Documents Received	Certified Copies						
KYC VEE	RIFICATION CARRIED OUT BY	INSTITUTION DETAILS					
	THE PROPERTY OF THE PROPERTY O	INSTITUTION DETAILS					
Date	D - M M - Y Y Y Y	Name					
Emp. Name		Code					
Emp. Code							
Emp. Designation							
Emp. Branch							

[^] Mask first 8 digits of your aadhaar number in claim form and claim documents submitted.



ICICI Lombard General Insurance Company limited

Mailing Address: ICICI Lombard Healthcare, ICICI Bank Tower, Plot No. 12, Financial District, Nanakram Guda, Gachibowli, Hyderabad, Telangana-500032

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

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