

## Do You Know

- To receive update on your claim status, provide your mobile no. & E-mail ID
- Track your claim status at: [www.icicilombard.com](http://www.icicilombard.com) Claims · Health Claims · Services · Track your claims

TO BE FILLED IN CAPITAL LETTERS ONLY

### Part - A (To be filled by Insured)

Name of Policy Holder:

Current Policy Number:

Card No./UHID:

Aadhaar No. of Policy Holder:

Only last 4 digits to be entered.

PAN No. of Policy Holder:

### Claimant Details

Name of Insured:

Current Residential Address:

City and State:

Pin Code:

Mobile No.:

Landline No.:

E-mail:

### Part - B (Claim Details)

|                                                |                      |       |                      |
|------------------------------------------------|----------------------|-------|----------------------|
| Date of Admission:                             | <input type="text"/> | Time: | <input type="text"/> |
| Date of Discharge:                             | <input type="text"/> | Time: | <input type="text"/> |
| Number of days of Hospitalization:             | <input type="text"/> |       |                      |
| Amount Claimed per day of Hospitalization (₹): | <input type="text"/> |       |                      |
| Total Claimed Amount (₹):                      | <input type="text"/> |       |                      |

Do You have any other insurance for similar claim (either with Us or with any other insurer)

If yes please specify details

| Name of the insurer | Policy / product name | Policy No. | Policy Period | Sum Insured |
|---------------------|-----------------------|------------|---------------|-------------|
|                     |                       |            |               |             |
|                     |                       |            |               |             |

### To be filled in case of Accidental Hospitalization

Nature of Injury: Industrial ☐ Domestic ☐ RTA ☐

If Injury type is Industrial/Domestic: Please provide Incident history

If Injury type is RTA: Please submit MLC / FIR copy

Date of Injury:  Time of Injury:  Place of Injury:

| Details of the amount claimed                                                                                      | Bill number | Bill date            | Bills attached       | Amount                 |
|--------------------------------------------------------------------------------------------------------------------|-------------|----------------------|----------------------|------------------------|
| Room rent                                                                                                          |             | <input type="text"/> | <input type="text"/> | ₹ <input type="text"/> |
| Doctors consultation/ Visit charges                                                                                |             | <input type="text"/> | <input type="text"/> | ₹ <input type="text"/> |
| Investigation charges (Includes Radiology and Pathology reports)                                                   |             | <input type="text"/> | <input type="text"/> | ₹ <input type="text"/> |
| Surgeon and Asst. surgeon charges                                                                                  |             | <input type="text"/> | <input type="text"/> | ₹ <input type="text"/> |
| Anesthetist charges & Operation theatre charges                                                                    |             | <input type="text"/> | <input type="text"/> | ₹ <input type="text"/> |
| Equipment charges/ Procedure charges                                                                               |             | <input type="text"/> | <input type="text"/> | ₹ <input type="text"/> |
| Cost of implant (If any)                                                                                           |             | <input type="text"/> | <input type="text"/> | ₹ <input type="text"/> |
| Pharmacy charges                                                                                                   |             | <input type="text"/> | <input type="text"/> | ₹ <input type="text"/> |
| Taxes/ Surcharges/ Service charge                                                                                  |             | <input type="text"/> | <input type="text"/> | ₹ <input type="text"/> |
| Miscellaneous/ Other charges                                                                                       |             | <input type="text"/> | <input type="text"/> | ₹ <input type="text"/> |
| Discount provided by hospital (If any)                                                                             |             | <input type="text"/> | <input type="text"/> | ₹ <input type="text"/> |
| <b>Total claimed amount (In `)</b> (Total claimed amount should be equal to the amount in attached bill documents) |             |                      |                      | ₹ <input type="text"/> |

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

(All claims shall be settled in electronic mode only, as per IRDA. Please provide correct bank account details)

Name of the Policy Holder:

Bank account number of Policy Holder:

Name of the Bank:

Branch Name:

IFSC of the Bank:  (should be same as per the provided cheque leaflet)

\*Policy holder is the person who has paid premium for the policy.

**EFT Mandate** ☐ Cancelled cheque copy (OR) ☐ Valid photo identity proof (self attested) (OR) ☐ Bank attested copy of passbook with IFSC

**ENCLOSURE CHECK LIST**

☐ Claim form duly filled & signed ☐ Copy of Discharge Summary ☐ EFT Mandate ☐ PAN Card Copy

☐ Any other documents \_\_\_\_\_

**In case of accidental hospitalisation below documents to be submitted in original.**

☐ Final bill ☐ Medicine bills with Prescriptions ☐ Investigation bills supported by Prescriptions & Reports ☐ Payment Receipts

**DECLARATION**

I hereby agree, affirm and declare that

- The statements / information given / stated in this claim form are true, correct and complete to the best of my knowledge and belief.
- 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.
- If I 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 shall not be entitled to all/any rights to recover there under in respect of any or all claims, past, present or future.
- The receipt of this claim form/other supporting/related documents does not constitute an agreement by the Company of the claim and the company reserve the right to process or reject or require further/additional information in respect of the claim.
- I also consent and authorize ICICI Lombard Health Care to seek medical information from any hospital/medical practitioner who has any time attended on the insured person.
- I hereby declare that I have included all the bills / receipts for the purpose of this claim & that I will not be making any supplementary claim
- I confirm that the expenses for which claim is being lodged have been incurred in respect of the insured.
- I/We hereby give my/our consent to the Company to verify and obtain my/our identity/address proof through Central KYC Registry or through any other modes for the purpose of undertaking KYC.

Place :

Date:

Signature of Claimant/ Policy Holder

**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

## Consent letter

### To Whomsoever It May Concern

Subject: Consent for Collection of Medical Records

Proposal No. / Policy No.: <PolicyNo. / Proposal No.>

I / We, the undersigned, hereby authorise ICICI Lombard General Insurance Company Ltd. to collect all relevant documents and medical records related to hospitalisation or medical treatment of Insured Person(s) covered under the above-mentioned policy from the Hospital or Medical Practitioner.

I/We have no objection to sharing my/our hospitalization documents with ICICI Lombard for the purpose of processing claims under the policy.

**Please note:** In case any original hospitalization or day-care treatment-related documents were collected by you at the time of discharge but were not submitted during the claim process, kindly ensure their submission to enable us to process the claim as per the policy terms and conditions.

Additionally, please send us a self-attested copy of a valid government-issued identity proof of the Claimant/Insured along with this consent letter.

Thank you for your assistance and cooperation.

Sincerely,  
Team ICICI Lombard.

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Name of the Insured

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Claimant / Insured Signature