CLAIM FORM: GROUP SAFEGUARD INSURANCE

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

You can lodge a claim with Us by any of the below means

- You can lodge a claim through Our website: www.icicilombard.com
- To register Your claim on the phone, please dial Our **Toll Free Number: 18002666**
- You can also mail Us on ihealthcare@icicilombard.com
- You may visit any of Our nearest branches and meet Our representatives

PART -I: Customer related details (To be filled by Insured Person/ claimant)

Note: Please attach a separate sheet if space available is not sufficient for filling in complete details.

A. Insured Person Details:

Policy No.: . . . . . .

Name of the Policyholder: . . . . . .

Name of the Insured Person: . . . . . .

Date of birth: . . / . . / . . . . Gender: Male . Female .

Aadhar Number: ☒☒☒☒☒☒☒☒ ☐☐☐☐ Only last 4 digits to be entered.

B. Claimant Details:

Name of claimant: . . . . . (Please ignore if Insured Person is claimant)

Relationship of claimant with Insured Person: . . . . . .

Address for communication: . . . . . .

Contact Details: Mob. . . . . / Res. No. . . . . .

Email Id: . . . . . .

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

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C. Loan Details (To be filled by Insured Person/ claimant if policy is linked to an underlying loan)

LAN No.: ·

Loan disbursed amount: · · · · · · · · · · · · · · · ·

Policy assigned: Yes · No · If yes, please mention the name of financial institution _____

PART- II: Claim Details

Loss Details

Claim No. (If claim has already been registered with ICICI Lombard Health Care): · · · · · · · · · · · · ·

Description of Loss/Event:
_____
_____
_____
_____
_____

In case of Injury/Permanent Total Disablement/ Death due to an Accident:

Was any FIR done: Yes · No · If yes, please share:

- Location of police station in which FIR registered:_____
- FIR no.:_____

In case FIR was not done, please state the reasons for same: _____

PART III: Hospital Details (To be filled by Insured Person/claimant/ Hospital authorities): Wherever applicable

Please specify the below details for all the Hospitals (In case more than one Hospital was visited)

Name of the Hospital: _____

Address of the Hospital: _____

Name of treating Medical Practitioner: _____

Nature of Injury/Illness: _____

Particulars of treatment: _____

_____

Date and time of admission: · · /· · /· · · · Time: ___AM/PM

Date and time of discharge: · · /· · /· · · · Time: ___AM/PM

Number of days in ICU (if any): _____

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Maternal Complication (if any): _____

Reasons for admission: Medical · Accidental ·

In case of admission due to Accident: Was any MLC done: Yes · No · In

case of death: Was any post mortem done: Yes · No ·

Was Insured Person suffering from any Pre-Existing Disease:

Signature of the Insured Person/claimant/Competent authority at treating Hospital
_____

For customer convenience, additional details and claim checklist will be shared with Insured Person/ claimant for only those Sections opted by customer in his/her Policy. However on the company website all Section(s) claim details and respective checklists shall be made available.

From the below set of documents only those Sections will be sent to customer which have been opted for.

Please tick against each of the Benefit under which You are claiming for, as per the relevant Section and Benefits. Also provide additional details specified against each of the Benefits in the table below.

The Insured Person/claimant will be eligible to claim for only those Benefits for which premium has been received by Us and Benefits have been specified in the Policy Certificate provided to You by Us.

SECTION -A (Accidental Injury Benefits)					
Please tick mark against relevant Benefit	**S. No.**	**Sections and Benefits**	**Trigger**	**Loss date and location**	**Additional Loss Details**
	A.1	**Death & Disability Related Benefits**			
·	**A.1.1**	Death Benefit	Accidental Death		
·	**A.1.2**	Permanent Total Disablement (PTD) Benefit	Permanent Total Disablement		
·	**A.1.3**	Permanent Partial Disablement (PPD) Benefit	Permanent Partial Disablement		
·	**A.1.4**	Temporary Total Disablement (TTD) Benefit	Temporary Total Disablement		Period of rest advised by treating Medical Practitioner: ___(weeks) From · · · · · · to · · · · · · Period of absence from work due to TTD: From · · · · · · to · · · · · ·
·	**A.1.5**	Common Carrier Accident Benefit	Accidental Death / Permanent Total Disablement		· Details of Carrier : · From and To locations:

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'	**A.1.6**	Adventure Sports Benefit	Accidental Death / Permanent Total Disablement		· Details of Adventure Sport: · Name of sports conducting academy/operators:
'	**A.1.7**	Children's Education Grant Benefit	Accidental Death		· No. of children under 25 years of age: · Name and Age of children
'	**A.1.8**	EMI Benefit	Temporary Total Disablement / Permanent Partial Disablement (>50%)		· EMI amount:
'	**A.1.9**	Loan protection Benefit	Accidental Death / Permanent Total Disablement		· Original amortization chart as on date of disbursal:
'	**A.1.10**	Mobility Benefit	Permanent Total Disablement/permanent total disability		
'	**A.1.11**	Orphan Benefit	Accidental Death		· No. of children : · Name and Age of children:
'	**A.1.12**	Repatriation of Mortal Remains Benefit	Accidental Death		· Location : · From : To:
'	**A.1.13**	Counselling Benefit	Accidental Death / Permanent Total Disablement		· Name & Address of counsellor
'	**A.1.14**	Parental care Benefit	Accidental Death / Permanent Total Disablement		· Details of parents : · Name : · Age :
'	**A.1.15**	Repatriation in case of Permanent Disability Benefit	Permanent Total Disablement		· From : To:
	A.2	**Hospitalization Expenses Related Benefits**			
'	**A.2.1**	Accidental Hospitalization Expenses Reimbursement Benefit	Accidental Injury		· Claimed Amount: · · · · · · · Date and time of admission · Date and time of discharge · No. of bills submitted will claim form:

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'	**A.2.2**	Accidental Pre & Post Hospitalization Expenses Benefit	Accidental Injury		· Pre-hospitalization Days : claimed amount · Post-hospitalization Days : claimed amount · No. of bills submitted will claim form:
'	**A.2.3**	Accidental Hospitalization Daily Cash Benefit	Accidental Injury		· Date and time of admission · Date and time of discharge · Claimed amount:
'	**A.2.4**	Air Ambulance Benefit	Accidental Injury		· From : To: · Claimed amount:
'	**A.2.5**	Comatose Benefit	Accidental Injury		· Date and time of admission · Date and time of discharge
'	**A.2.6**	Broken Bones Benefit	Accidental Injury		· Date and time of admission · Date and time of discharge
'	**A.2.7**	Compassionate Visit Benefit	Accidental Injury		· Name of person travelling: · Relation with the Insured Person: · Mode of transport · Location from and to: · Date of travel:
'	**A.2.8**	Burns Benefit	Accidental Injury		
'	**A.2.9**	Ambulance Charges Benefit	Accidental Injury		· From : To: · Claimed amount: · Reason for ambulance service
	A.3	**Other Benefits**			
'	**A.3.1**	Assault Benefit	Accidental Injury		
'	**A.3.2**	Mysterious Disappearance Benefit (Along with Corresponding Proof of Travel)	Disappearance while travelling in defined Common Ccarrier Accident		· Details of Common Carrier : · From and To location: · Date of start of journey: · Date of end of journey:

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Claim documents required for Section A (The below documents need to be provided against each of the Benefits under which the Insured Person/claimant is claiming for)

Documents Required for Section A.1													
S. No.	**Benefit Name**	**Claim Form**	**MLC or FIR**	**Cause f eat eath Certificate a certificate by unicipal corporation**	**Post Mortem Report**	**Viscera / Che ical nalysis / F re sic rt**	**Police Final Charge Sheet / rt Fi al r r**	**Spot / I est Panchnama**	**isa ility rtificate issued by civil or government Hospital**	**Indoor case papers**	**Medical Certificate**	**Fitness Certificate**	**Leave ertificate fro the employer**
A.1.1	**Death Benefit**		. . .	. .	.	. .	. .	. .		. .			
A.1.2	**Permanent Total Disablement (PPD) Benefit**		. . .				. .	. .	. .	. .	. .		
A.1.3	**Permanent Partial Disablement (PPD) Benefit**		. . .				. .	. .	. .	. .	. .		
A.1.4	**Temporary Total Disablement (TTD) Benefit**		. . .								. .	. .	
A.1.5	**Common Carrier Accident Benefit**	Documentation requirement mentioned against Benefit A.1.1 or Benefit A.1.2 (As per the nature of Injury) **& Proof of Travel (Ticket or boarding pass)**											
A.1.6	**Adventure Sports Benefit**	Documentation requirement mentioned against Benefit A.1.1 or Benefit A.1.2 (As per the nature of Injury) & **proof of participation in adventure sports such as tickets.**											
A.1.7	**Children's Education Grant Benefit**	Documentation requirement mentioned against Benefit A.1.1 or Benefit A.1.2 (As per the nature of Injury) **& Bonafide Certificate from the educational institute certifying the enrolment of the Insured Person's child in his/her educational course** **Proof of relationship of children with Insured Person such as passport/election card / PAN card Age proof of children such as passport,/ election card / PAN card**											
A.1.8	**EMI Benefit**	Documentation requirement mentioned against Benefit A.1.3 or Benefit A.1.4 (As per the nature of Injury) **& Loan Sanction Letter & Loan Disbursement Letter (including the repayment schedule) & Statement of Account as on date of loss**											
A.1.9	**Loan protection**	Documentation requirement mentioned against Benefit A.1.1 or Benefit A.1.2 (As per the nature of Injury) **& Loan Sanction Letter & Loan Disbursement Letter , Original amortization schedule on disbursal letter, statement of account as on date of loss**											

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	Benefit	
A.1.10	**Mobility Benefit**	Documentation requirement mentioned against Benefit A.1.2 .
A.1.11	**Orphan Benefit**	As per documentation requirement mentioned against Benefit A.1.1 & **Death Certificate of the Insured's spouse Proof of relationship of children with insured such as passport,/ election card / PAN card Age proof of children such as passport,/ election card / PAN card**
A.1.12	**Repatriation of Mortal Remains Benefit**	Documentation requirement mentioned against Benefit A.1.1 **& All original bills associated with the repatriation expenses**
A.1.13	**Counselling Benefit**	Documentation requirement mentioned against Benefit A.1.1 or Benefit A.1.2 (As per the nature of Injury)& Proof of counselling sessions along with councillors prescription or certificate
A.1.14	**Parental care Benefit**	Documentation requirement mentioned against Benefit A.1.1 or Benefit A.1.2 (As per the nature of Injury)& proof of relation such as passport, birth certificate school/college leaving certificate of Insured Person
A.1.15	**Repatriation in case of Permanent Disability Benefit**	Documentation requirement mentioned against Benefit A.1.2 **& All original bills associated with the repatriation expenses**

	CLAIMS DOCUMENTS FOR SECTION A.2										
S.No.	**Benefit Name**	**Claim Form**	**Indoor as Papers**	**MLC/ FIR**	**All Diagnostic Reports**	**Complete Hospital bills**	**Discharge Summary**	**ll rec i ts ills r late to pre and post Hospitalization**	**ll r c i ts r lat t avail ent of any Ambulance services**	**Certificate fro edical Practitioner**	**ll rec i ts r late to avail t f y Travel Service t r g a licensed Common Carrier**
A.2.1	**Accidental Hospitalization Expenses Benefit**	. .	. .	. .	. .	. .	. .	.		.	
A.2.2	**Accidental Pre & Post Hospitalization Expenses Benefit**	. .	. .	. .	. .	.	. .	. .	.	. .	.
A.2.3	**Accidental Hospitalization Daily**	. .	. .	. .	. .	. .	. .	.	.	. .	.

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	Cash Benefit										
A.2.4	**Air Ambulance Benefit**	. .	.	. .	.	.	. .		. .	. .	.
A.2.5	**Comatose Benefit**	. .	. .	. .	. .	. .	. .			. .	
A.2.6	**Broken Bones Benefit**	. .	. (In case of Hospitalization)	. .	. .	. .	. .			. .	
A.2.7	**Compassionate Visit Benefit**	. .		. .							. .
A.2.8	**Burns Benefit**	. .	. .	. .	. .	. .	. .	.		. .	
A.2.9	**Ambulance Charges Benefit**	. .	.	.	.	.	. .	.	.	.	.

	CLAIMS DOCUMENTS FOR SECTION A.3						
S.NO.	**Benefit Name**	**Claim Form**	**MLC or FIR**	**Spot or Inquest Panchnama**	**Police Final Charge sheet**	**Hospital discharge summary**	**Indoor case papers**
A.3.1	**Assault Benefit**	. .	. .	. .	. .	. .	. .
A.3.2	**Mysterious Disappearance Benefit**	. .	Police certificate confirming disappearance	. .	. .	.	.

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Please tick against each of the Benefit under which You are claiming for, as per the relevant Section and Benefits. Also provide additional details specified against each of the Benefits in the table below.

The Insured Person/claimant will be eligible to claim for only those Benefits for which premium has been received by Us and Benefits have been specified in the Policy Certificate provided to You by Us

Section B (Animal, Reptile & Insect Attack Benefits)					
Please tick mark against relevant Benefit	**S. No.**	**Sections and Benefits**	**Trigger**	**Loss Date**	**Additional Loss Details**
.	**B.1**	Death due to Animal, Insect & Reptile Attack Benefit	Accidental Injury caused by animal, and/or reptile attack/bite or sting/bite of an insect		
.	**B.2**	Permanent Total Disablement (PTD) due to Animal, Insect & Reptile Attack Benefit			
.	**B.3**	Hospitalization Expenses due to Animal, Insect & Reptile Attack Reimbursement Benefit			• Date and time of admission • Date and time of discharge • No. of bills submitted will claim form:

Claim documents required for Section B (The below documents need to be provided against each of the Benefits under which the Insured Person/claimant is claiming for)

	Benefit Name	**MLC or FIR**	**Cause of eath rtifi t**	**Post orte Report**	**icera / Che ical nalysis / Forensic**	**Police Final Charge Sheet / C rt Fi al Order**	**Spot / Inquest Panchnama**	**isa ility Certificate**	**Indoor case rs**	**edical Certificate**	**ischarge Summary**	**Co plete Hospital bills**
B. 1	**Death due to Animal , Insect and Reptile Attack Benefit**	. .	. .	. .	. .	. .	. .		. .	. .		
B. 2	**PTD due to Animal, Insect and**	. .				. .	. .	. .	. .	. .		

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	Reptile Attack Benefit											
B. 3	**Hospitalization Expenses due to Animal, Insect & Reptile Attack Benefit**	. .				. .	. .	.	. .	. .	. .	. .

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Please tick against each of the Benefit under which You are claiming for, as per the relevant Section and Benefits. Also provide additional details specified against each of the Benefits in the table below.

The Insured Person/claimant will be eligible to claim for only those Benefits for which premium has been received by Us and Benefits have been specified in the Policy Certificate provided to You by Us

Section C (Specific Vector Borne Disease or Malaria Benefit)					
Please tick mark against relevant Benefit	**S. No.**	**Sections and Benefits**	**Trigger**	**Loss Date and Location**	**Additional Loss Details**
	C.1	**Specific Vector Borne Disease Benefit**			
.	**C1.1**	Specific Vector Borne Disease related Hospitalization Benefit	Specific Vector Borne Disease due to sting/bite/attack		Please tick against the diseases • Dengue • Chickungunya • Kala-Azar • Japanese encephalitis • Filariasis • Date and time of admission • Date and time of discharge
	C.2	**Malaria Benefit**			
.	**C2.1**	Malaria related Hospitalization Benefit	Malaria due to sting/bite/attack		• Date and time of admission • Date and time of discharge

Claim documents required for Section C (The below documents need to be provided against each of the Benefits under which the Insured Person/claimant is claiming for)

	CLAIMS DOCUMENTS FOR SECTION C.1		
S.No.	**Benefit**	**Documents common for all Specific Vector Borne Disease**	**cific reports signed and attested by registered pathologist which confirm following diagnosis and laboratory findings positively**

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			Dengue	Chickungunya	Kala-Azar	Japanese encephalitis	Filariasis
C1.1	**Specific Vector Borne Disease related Hospitalization Benefit**	Duly filled claim form	NS1 antigen test or Ig M- Elisa test	Presence of IgM and IgG anti chikungunya antibodies.	Direct Agglutination Test or Rapid dipstick test or ELISA for detecting IgG	Ig M antibody detection in serum or cerebrospinal fluid	Antigen detection in blood sample or IgG4 antibody detection using routine assays
		Out-patient consultation paper			Anemia, Leucopenia, thrombocytopenia and Hypergammaglobulinemia		
		Hospital Discharge summary duly signed and attested by treating doctor confirming the diagnosis					
		Indoor case papers of treating hospital					

	CLAIMS DOCUMENTS FOR SECTION C2.1						
C2.1	**Malaria related Hospitalization Benefit**	Claim form	Diagnosis must be confirmed positive/reactive by microscopy or malaria rapid diagnostic test (RDT) signed and attested by registered pathologist	Treating Medical Practitioner certificate(duly filled and attested) confirming diagnosis as Malaria	Outpatient consultation paper (wherever applicable)	Hospital discharge summary	In door case papers of the Hospital

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Please tick against each of the Benefit under which You are claiming for, as per the relevant Section and Benefits. Also provide additional details specified against each of the Benefits in the table below.

The Insured Person/claimant will be eligible to claim for only those Benefits for which premium has been received by Us and Benefits have been specified in the Policy Certificate provided to You by Us

Section D (Maternal Complication Benefit)				
Tick Here	**Benefit Details**	**Trigger**	**Loss Date**	**Additional Loss Details**
·	**Maternal Complication Benefit**	**Defined maternal complication**		**Please select the type of Maternal Complication** · Eclampsia · Abrupto Placenta · Placenta Increta · Placenta Percreta, · Amniotic Fluid Embolism · Acute Fatty Liver of Pregnancy · Disseminated Intravascular Coagulation · Still Birth · Pre Eclampsia · Medical Termination of Pregnancy · Hyperemesis Gravidarum · Ectopic Pregnancy Any other maternal complication_____ · Date of conception · Date and time of admission · Date and time of discharge

Claim documents required for Section D (The below documents need to be provided against each of the Benefits under which the Insured Person/claimant is claiming for)

Maternal Complication Benefit	Claim form	All medical and diagnostic reports including first USG report indicating the date of conception	Certificate from Attending Obstetrician clearly indicating the final diagnosis.	Indoor case papers of treating Hospital (including cause of death certificate, if applicable)	Hospital Discharge summary duly signed and attested by treating Medical Practitioner	All past outpatient consultation related to the pregnancy

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Please tick against each of the Benefit under which You are claiming for, as per the relevant Section and Benefits. Also provide additional details specified against each of the Benefits in the table below.

The below table specifies all the covers available under this product. The Insured Person/claimant will be eligible to claim for only those Benefits for which premium has been received by Us and Benefits have been specified in the Policy Certificate provided to You by Us

Section E - (Hospital Daily Cash - Ilness					
Please tick mark against relevant Benefit	**S.No.**	**Sections and Benefits**	**Trigger**	**Loss Date**	**Additional Loss Details**
'	**E.1**	Hospital Daily Cash Benefit	Hospitalization		• Number of days of non ICU Hospitalization: • Date of admission • Date of discharge
'	**E.2**	Intensive Care Unit (ICU) Cash Benefit	Hospitalization		• Number of days of ICU Hospitalization: • Date of admission in ICU: • Date of discharge from ICU:
'	**E.3**	Emergency Medical Services Benefit	Hospitalization		• Location : • From : To:

Claim documents required for Section E (The below documents need to be provided against each of the Benefits under which the Insured Person/claimant is claiming for)

CLAIMS DOCUMENTS FOR SECTION E					
Daily Cash and Intensive Care Unit (ICU) Cash Benefit	Claim form	Indoor case papers of treating Hospital	Hospital Discharge summary filled and attested by Hospital authorities	First Information Report (F.I.R.) copy / Medico-legal case papers - Notarized/ Attested by a gazetted officer in case of an Accidental Injury	Complete Inpatient bill

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PART- IV: NEFT Details

Please provide any one of the below documents of the claimant or Insured Person's whose name has been explicitly stated in the Policy Certificate:

- Self-attested copy of a valid Identity proof of the claimant/Insured Person's (provide any of the mentioned documents in Proof of Identity under Part-V)
- Cancelled cheque copy Bank attested copy of Passbook with IFSC code - For Refunds ,Copy of Passbook with IFSC Code, Account Number, Bank Logo and Account holder Name if cancelled cheque does not contain accountholder name

Please provide below details (All fields are mandatory)

- Claimant /Insured Person's name(as per bank records: . . . . . .
- Claimant /Insured Person's 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)

*Nominee's bank account details are required in case of a death claim.

Terms and Conditions for payments through RTGS/NEFT

1. The details provided by the claimant / Insured Person in the Mandate Form provided by us 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 claimant / Insured Person 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 claimant / Insured Person agrees that under the RTGS/ NEFT facility, there may be a risk of non-payment in the claimant / Insured Person bank account 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 claimant / Insured Person 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 claimant/ Insured Person 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 General Insurance Company Ltd. 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 claimant/ Insured Person will be acknowledged through a confirmation letter by ICICI Lombard General Insurance Company Ltd. In no case can the claimant/ Insured Person construe his termination notice as effective unless a confirmation has been provided by ICICI Lombard General Insurance Company Ltd. to the claimant/ Insured Person stating the date of receipt of such communication by the claimant/ Insured Person.
7. The claimant/ Insured Person agrees that transaction(s) through RTGS/ NEFT facility may attract inward RTGS/ NEFT charges, which if levied by the claimant/ Insured Person's bank, shall be borne by the claimant/ Insured Person only

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8. ICICI Lombard General Insurance Company Ltd. has the absolute discretion to amend or supplement any Terms and Conditions stated herein at any time and will endeavour 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 claimant/ Insured Person 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 ICICI Lombard General Insurance Company Ltd..
10. Notices under these Terms and Conditions may be given in writing by delivering them by hand, or e-mail, or displaying them on ICICI Lombard General Insurance Company Ltd. Website "www.icicilombard.com", or by sending them by post to the last address of the claimant/ Insured Person.
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.

Claimant/Insured Person Declaration:

12. I/we 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 my/our knowledge 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 claimant/ Insured Person.

Place: . . . . . Date: . . . . . .

Signature_____

PART - V: KYC (KNOW YOUR CUSTOMER)

KYC required if claim amount is greater than 1 lakh

Claimant/Insured Person's Name: . . . . . (in respect of whom claim is made)

Policy Number: . . . . . .

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

. . . . . .

PAN No.: . . . . . .

The below KYC documents are mandatory as per Our internal guidelines, and AML guidelines issued by the IRDAI:

- Two passport size photos of Insured Person/claimant (stick in the space provided below)
- One photocopy of proof of identity of Insured Person/claimant (any 1 in the below list)
- Passport
- PAN card
- Voter's Identity card
- Driving license

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- Personal identification and certification of the employees of the insurer for identity of the prospective Policyholder
- Job card issued by NREGA duly signed by an officer of the State Government
- Letter from a recognized Public Authority (as defined under Section 2 (h) of the Right to Information Act, 2005) or Public Servant (as defined in Section 2(c) of the 'The Prevention of Corruption ct, 1988') verifying the identity and residence of the customer
- One photocopy of proof of residence of Insured Person/claimant (any 1 in the below list)
- Electricity bill
- Ration card
- Letter from any recognized public authority
- Current statement of bank account with details of permanent/ present residence address (as downloaded)
- Current passbook with details of permanent/present residence address (updated upto the previous month)
- Valid lease agreement along with rent receipt, which is not more than three months old as a residence proof.
- Telephone bill pertaining to any kind of telephone connection like, mobile, landline, wireless, etc. provided it is not older than six months from the date of insurance contract
- Employer's certificate as a proof of residence (Certificates of employers who have in place systematic procedures for recruitment along with maintenance of mandatory records of its employees are generally reliable)

Claimant/Insured Person Declaration:

I hereby agree, affirm and declare that:

a) The statements/Information stated by me/us in the claim form are true, correct and complete.

b) No material information which is relevant to the processing of claim on which in any matter has been withheld or not disclosed.

c) I authorise ICICI Lombard General Insurance Company Ltd. to collect on my behalf any medical information from concerned Hospital authorities such as indoor case papers, viscera reports, investigation reports etc or any other information such as FIR/ death certificate etc from any other institutions relevant to this claim.

d) If I have given/made any false or fraudulent statement/information, or suppressed or concealed or in manner failed to disclose material information, the policy shall be void and that I shall not be entitled to all/any rights to recover thereunder in respect of any or all claims past, present or future.

e) The receipt of this claim form/ other supporting/ related document does not constitute or be deemed to constitute an agreement by ICICI Lombard General Insurance Company Ltd. of the claim and ICICI Lombard General Insurance Company Ltd. reserves the rights to process or reject or require further/additional information in respect of any claim.

f) The policy shall become void at the option of the insurer, in the event of any untrue or incorrect statement, misrepresentation, non-description or on non-disclosure in any material particularly in the claim form/personal statement, declaration and connected documents, or any material information or having been withheld by the Insured Person or any one acting on his behalf.

g) I/We hereby give my/our consent to the Company to verify and obtain my/our identity/address proof through Central KYC Registry or UIDAI or through any other modes for the purpose of undertaking KYC.

Name of the Insured Person/claimant/Nominee: . . . . . Relation with the Insured Person: . . . . . .

Place: . . . . . Date: . . . . . .

Signature_____

Mailing Address: ICICI Lombard Healthcare, Varun Tower II, 1st, 4th, 5th & 6th Floor, Begumpet, Hyderabad, Telangana, Pincode – 500016. Visit Us at: www.icicilombard.com • E-Mail Us at: ihealthcare@icicilombard.com • Toll Free Number: 1800 2666 • CIN No. [L67200MH2000PLC129408] • IRD Registration No. 115

ICICI Lombard

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.

_____ _____

Name of the Insured Claimant / Insured Signature

12/Dec/2024/0001