

PORTABILITY / MIGRATION FORM

PART - I

Proposal Form No: _____

Please ensure that the details furnished in this form are correct and complete in all respects. The company's decision for acceptance of the risk will be on the basis of information provided below and the relevant supporting documentation. In case of any doubt regarding the information to be provided, please seek advice from your insurance advisor or agent. Please attach additional sheets if required. ICICI Lombard General Insurance Co Ltd reserves the right to cancel the policy issued to the customer in case of any PED or claims history is found in the policy held with the previous insurer.

Please fill only the relevant sections as per the requirement for portability (from other insurers retail health insurance policy to ICICI Lombard retail health policy) or Migration (from ICICI Lombard group health policy to ICICI Lombard retail Health policy).

DETAILS OF POLICY HOLDER

Name of the Policyholder : _____
 Date of Birth : Gender: M ☐ F ☐ T ☐
 Address of the Policyholder: _____

 Mobile No. : _____ Email ID : _____

DETAILS OF PROPOSED INSURANCE

Product Name : _____

Sum Insured opted for (₹) : _____ Reasons for Portability/Migration : _____

No. of members to be covered

What was the cumulative bonus in previous policy: _____

Whether cumulative bonus to be converted to an enhanced Sum Insured. Yes ☐ No ☐

DETAILS OF PAST / EXISTING HEALTH INSURANCE POLICIES

Please provide the below-mentioned details of continuous health insurance policies for a maximum of past 4 years, pertaining to all insured(s) for whom Portability/Migration cover is required.

PORTABILITY/MIGRATION FORM - PART A

ONLY APPLICABLE FOR MIGRATION

Name of the Employee: _____
 Employee ID: _____ Company: _____

Sr. No.	Insured Name	Date of Birth	No of years covered in previous policies	Pre-Existing diseases	Sum Insured	Additional Sum Insured / Cumulative Bonus	Date of joining (with first Insurer)
1							
2							
3							
4							
5							

DETAILS OF THE PAST RETAIL HEALTH INSURANCE POLICIES / DETAILS OF THE PAST GROUP HEALTH INSURANCE POLICY OF ICICI LOMBARD - PART B

Sr. No.	Policy Number/ UHID	Policy Start Date	Policy End Date	Name of the Policy	Add ons/Riders in the policy
1					
2					
3					
4					

DETAILS OF PAST CLAIMS

Sr. No.	Policy Number/ UHID	No of claims	Claim amount	Nature of claim
1				
2				
3				
4				

Note: Please use additional sheet, if space is not sufficient to complete details.

1. Have you or any person proposed to be insured under the Policy ever refused Insurance cover by an Insurance company or been accepted on special terms? Yes ☐ No ☐

If yes, please give full details. _____

2. Have you or any person proposed to be insured under the policy ever covered Maternity Benefit? Yes ☐ No ☐

i) Policy Duration _____ ii) Maternity Sum Insured _____

As per regulatory requirements, ICICI Lombard must receive information from previous insurer in time to process your application.

