

Smart Janata Personal Accident Insurance Policy

Claim Form

Policy No		Claim No.	
		Date of registration	
Branch Office Code			
Name & Code of Intermediary			

1. Name of the Insured / Insured Person	
2. Customer ID	
3. Address of the Insured / Insured Person	
4. Profession or Occupation	

Policy details	
Sum Insured	
Cover	

Details of Accident

5. Name of the insured person	
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ICICI Lombard General Insurance Company Limited

IRDA Reg. No. 115

CIN: L67200MH2000PLC129408

UIN : IRDA/NL-HLT/BAXAGI/P-P/V.I/87/13-14
 SMART JANATA PERSONAL ACCIDENT INSURANCE

Mailing Address:
 601 & 602, 6th Floor, Interface 16,
 New Linking Road, Malad (West)
 Mumbai - 400 064

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

Toll free no : 1800 2666
Alternate no : 86552 22666 (chargeable)
E-mail : customersupport@icicilombard.com
Website : www.icicilombard.com

6. a) Date of the Accident b) Time of the Accident c) Where it happened? d) Name & Address of the Witness	
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7. How did the Accident occur?	
8. Nature of Injury received (if to limb or Eye state whether right or left)	
9. a) Nature of disablement b) Extent of disablement	
10. Name and address of Surgeon in attendance	
11. Where and when can a Medical Officer of our Company visit you, if necessary?	
12. a) Are you insured in any other Office or Offices granting compensation for accident? b) If so state name and address of company or Companies and amount of Insurance	

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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I hereby declare that the foregoing statements are true in all respects and that I have not attempted to conceal from The Company anything with which it ought to be made acquainted and also that if I have made or in any further declaration the Company may require shall make any false or fraudulent statement or any suppression, Concealment or untrue averment whatever, the Policy shall be void and my right to compensation forfeited and I am willing if required, to make a statutory Declaration before a Justice of the Peace of the truth of the whole of the foregoing statement or any other statement. I may make in connection with this claim. 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.

Signature of the Insured / Insured Person / nominee / legal representative(s)

Date

Address

Date

Witness

Signature

Name

Address

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MEDICAL CERTIFICATE

(Claim must be supported by the Medical Evidence to be furnished by the Insured/Insured Person at his/her expense)

Name of Claimant _____ Age _____

1. Nature and cause of Accident
2. If to eye or limb, state left or right.
3. Whether the appearance of the injuries are consistent with the account given of the accident.
4. Date on which you first attended claimant for this injury.
5. Has claimant been totally prevented from attending to any portion of his/her business/occupation/normal duties? If so for how long?
6. Is claimant suffering from any disease or illness apart from his injury and is there any illness by circumstances which may tend to retard recovery? If so, give particulars.
7. Present condition.

Having personally examined the above named Insured, I certify that the above statements are correct and that the injured person is necessarily disabled by the accident referred to.

Signature:

Name:

Qualification:

Address:

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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