

ICICI LOMBARD HEALTH CARE CLAIM FORM - TRIPSECURE PLUS

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

Guidelines for completion of Claim Form

1. Claim form consists of Part A (with annexure), Part B and Part C.
2. Please fill the Part A along with the relevant Annexure as per the desired coverage.
3. Please take print out of the relevant coverage only.
4. Please send the claim form along with the claim documents as shared on LOR for claim proceeding

S No.	Part - A	To be filled by	Required to
1	A1- Policy Details	Insured/Claimant/Nominee	To track Insured details and to ensure timely communication
2	A2- Insured Details		
3	A3- Claimant Details		

S No.	Annexures	Coverage	Page Number (Please tick whichever is applicable) ☒
1.	Annexure I	Domestic Personal accident cover	☐
2.	Annexure II	En-Route Personal Accident Cover-Common Carrier	☐
3.	Annexure III	Accidental Hospitalization Expenses	☐
4.	Annexure IV	En-Route Accidental Hospitalization Expenses-Common Carrier	☐
5.	Annexure V	Domestic OPD Expenses	☐
6.	Annexure VI	En-Route OPD Expenses- Common Carrier	☐
7.	Annexure VII	Domestic Loss of Baggage & Personal effects	☐
8.	Annexure VIII	Theft / Burglary of Home contents	☐
9.	Annexure IX	Missed connection	☐
10.	Annexure X	Domestic Trip Cancellation and Interruption	☐
11.	Annexure XI	Domestic Loss of checked in Baggage	☐
12.	Annexure XII	Domestic Delay of Checked In Baggage	☐
13.	Annexure XIII	Domestic Flight Delay – Fixed Benefit	☐
14.	Annexure XIV	Domestic Airline-Operated Cancellation Benefit	☐
	Part B	Insured	For electronic fund transfer to bank account ☐
	Part C - KYC	Insured	As per IRDA guidelines, for All claims ☐

Documents Submitted

Common Documents

S No	Document	Yes	No	Type of Document Original / Photocopy
1	Claim Form	☐	☐	
2	Policy Certificate	☐	☐	
3	Ticket/Boarding pass issued by service provider	☐	☐	
4	Incident letter	☐	☐	
5	Copy of ID proof	☐	☐	
6	Cancelled cheque (in case NEFT form not attested by bank)	☐	☐	
7	Declaration letter (in case if claim being settled into account other than Insureds)	☐	☐	

Specific documents depending on benefit claimed

S No	Document	Yes	No	Type of Document Original / Photocopy
1	Bills and receipt for additional expenses (food / stay/alternate travel arrangement)	☐	☐	
2	Bills and receipt for medical expenses (hospital/investigations/medicines/consultation)	☐	☐	
3	Communication from service provider (trip cancellation/delay , baggage loss/baggage delay)	☐	☐	
4	Refund voucher/details from service provider for cancellation/compensation	☐	☐	
5	PIR (property irregularity report) from service provider	☐	☐	
6	Delivery receipts from service provider	☐	☐	
7	Discharge summary and medical reports	☐	☐	
8	Death certificate/ Post mortem report	☐	☐	
9	FIR/Panchanma	☐	☐	
10	Others pls specify	☐	☐	
11	Others pls specify	☐	☐	

Please send the completely filled and signed claim form along with the supporting claim documents (as per LOR - Letter of requirement) to the below mentioned address for further claim processing

Mailing Address: ICICI Lombard Healthcare, Varun Tower II, 1st, 4th, 5th & 6th Floor, Begumpet, Hyderabad, Telangana, Pincode – 500016.

ICICI LOMBARD HEALTH CARE CLAIM FORM - TRIPSECURE PLUS

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

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

PART A

A1 POLICY DETAILS

(To be filled by Insured)

Policy No.:
 Policy Start Date: / /
 Policy End Date: / /

A2 INSURED DETAILS

(First) (Middle) (Last)
 Full Name:
 Date of Birth: / /
 Sex: Male ☐ Female ☐
 Current Address:
 Address in Country of Residence:
 Phone No. Overseas: Phone No. India: (With STD Code)
 Mobile No: Email ID:
 Claims Ref No.:(As provided)

Every claim has to be accompanied with original ticket/ boarding pass or copy of the passport indicating the travel dates.

A3 CLAIMANT INFORMATION (If different than "Insured Information" above)

Full Name:
 Date of Birth: / /
 Sex: Male ☐ Female ☐ Relationship with the Policyholder:
 Claimant's Address:
 Phone No. (Off): Phone No. (Res):
 Email ID:
 In what capacity are you making this claim? ☐ Self ☐ Nominee ☐ Insured's Relative Specify

Terms and conditions

- The Insured shall ensure that the Insured has received, read and understood the terms and conditions as contained in Part II and III of the Policy. If the Insured has not received Part II and Part III of the Policy, please email at customersupport@icicilombard.com.
- In the event of an Accident or sudden Illness or occurrence of any other contingency covered under the Policy, the Insured shall immediately contact the Help Line number and register his/ her claim furnishing the necessary details.
- Please note, Deductible amount as mentioned in Policy Schedule must be borne by you.
- Issuance of the claims form is not an admission of liability or a waiver of terms, conditions & exceptions of the insurance contract.
- No claim under Accident & Medical Section will be admitted without Doctor's Report as per format.
- Please answer all questions completely. In case of insufficient space, please attach additional sheets.
- Please attach original of all bills, receipts, credit card slips pertaining to your claim. Every claim has to be accompanied with original ticket/ boarding pass or copy of passport indicating the travel dates.

DECLARATION / AUTHORISATION (By Insured / On behalf of Insured)

I/We hereby agree, affirm and declare that:

- The statements/ information given/ stated by me/ us in this claim form are true, correct and complete.
- The details of all persons having an interest in the property in respect of which the claim is being made are provided as per the proposal form or by way of an endorsement in the policy. Furthermore, save and except as provided or disclosed in this claim form, no claim made hereunder (or the same/ similar claim) has been made or lodged with any other insurance company.
- 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/ We 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/ We shall not be entitled to all/any rights to recover thereunder in respect of any or all claims, past, present or future.
- The receipt of this claim form/other supporting/related documents does not constitute or be deemed to constitute an agreement by the Company of the claim and the Company reserves the right to process or reject or require further/additional information and documents in respect of the claim.
- I do hereby authorize International Subrogation Management (ISM) to inquire and obtain any information regarding my accident. Further, ICICI Lombard is hereby authorized to release any and all information, including copies of pertinent documents, which ISM may deem necessary in order to satisfy their inquiry, If during the investigation, ISM has identified a potential recovery source, allowing the Plan Participant's employer to recover paid benefits, ISM is authorized to release any all records they deem necessary in order to pursue the recovery.

7. The company can, while assessing the claim, call for the additional documents which the Company deems fit for assessment of the claim.
8. I authorize any insurance company, physician, hospital or other healthcare provider, or any other organization, institution or person that may have records, documents or knowledge regarding the Insured to release any information requested regarding this claim and the loss reported.
9. I understand ICICI Lombard General Insurance Company Ltd, or its authorized representatives, for the purpose of evaluating and determining coverage for this claim, will use this information.
10. I know I have a right to receive a copy of this authorization upon request and agree that a photographic or facsimile copy of this authorization is as valid as the original.
11. I agree that this authorization shall be valid for the duration of this claim. I also authorize Assistance Service Provider, on behalf of ICICI Lombard General Insurance Company Limited, to obtain any medical records or information to process this claim.
12. I understand that any person who knowingly and with intent to defraud or deceive any insurance company files a claim containing any materially false, incomplete or misleading information may be subject to prosecution for insurance fraud.

Dated: / /

If Claimant, Relationship with the Insured:))))))))))))))))

Place:

Insured's Signature

Claimant or authorized person Signature

ANNEXURE I - DOMESTIC PERSONAL ACCIDENT COVER

Please state circumstances of accident i.e. how, when, where it took place :

[illegible]

Nature of Injury :

State diagnosis and nature of treatment / surgery under taken :

Provide name, address & telephone umber of Hospital / Clinic :

[illegible]

Treating Doctor's Name & Qualifications :

Treating Doctor's Telephone Number : (O) _____ (M) _____ Room /Ward / Bed Number : _____

Dates of treatment : From / / To : / /

Attending Doctor's Report

Date doctor contacted : D D / M M / Y Y Y Y H H : M M

Nature of Ailment :

[illegible]

State diagnosis and nature of treatment provided :

Describe any other disease or infirmity affecting present condition

Was the accident due to Pregnancy : Yes ☐ No ☐ (Tick the appropriate)

Was the accident due to any pre-existing condition : Yes ☐ No ☐ (Tick the appropriate)

If yes, please give details :

Can the patient be evacuated back to the Republic of India ? Yes ☐ No ☐ (Tick whichever appropriate)

Loss Incurred (Please tick) :

Death

Permanent Total Disability : (Details) Write Here

Permanent Partial Disability : (Details) Write Here

Medical Doctor's Signature and Date : D | D | / M | M | / Y | Y | Y | Y

Documents to be submitted in support of the claim :

1. Medical reports giving the details of the Accident, nature of Injury and the extent of disability. Certified by Medical Practitioner.
2. In case of death of the Insured, death certificate issued by the Medical Practitioner who attended on the Insured.
3. Postmortem certificate to be produced if required by the Third Party Administrator. Police report in original in case the Accident shall have taken place in a public place or premises.

ANNEXURE II - EN-ROUTE PERSONAL ACCIDENT COVER-COMMON CARRIER

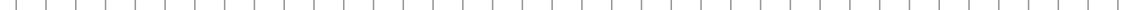
Please state circumstances of accident i.e. how, when, where it took place :

[illegible]

Nature of Injury :

[illegible]

State diagnosis and nature of treatment / surgery under taken :



Provide name, address & telephone number of Hospital / Clinic :

Treating Doctor's Name & Qualifications :

Treating Doctor's Telephone Number : (O) (M) Room /Ward / Bed Number :

Dates of treatment : From / / To : / /

Attending Doctor's Report

Date doctor contacted : D | D | / M | M | / Y | Y | Y | Y | H | H : M | M |

Nature of Ailment :

State diagnosis and nature of treatment provided :

Describe any other disease or infirmity affecting present condition

Was the accident due to Pregnancy : Yes ☐ No ☐ (Tick the appropriate)

Was the accident due to any pre-existing condition : Yes ☐ No ☐ (Tick the appropriate)

If yes, please give details :

Can the patient be evacuated back to the Republic of India ? Yes ☐ No ☐ (Tick whichever appropriate)

Loss Incurred (Please tick) :

Death

Permanent Total Disability : (Details) Write Here

☐ Permanent Partial Disability : (Details) Write Here

Medical Doctor's Signature and Date : D | D | / M | M | / Y | Y | Y | Y |

Documents to be submitted in support of the claim :

1. Medical reports giving the details of the Accident, nature of Injury and the extent of disability. Certified by Medical Practitioner.
2. In case of death of the Insured, death certificate issued by the Medical Practitioner who attended on the Insured.
3. Postmortem certificate to be produced if required by the Third Party Administrator. Police report in original in case the Accident shall have taken place in a public place or premises.

ANNEXURE III - ACCIDENTAL HOSPITALIZATION EXPENSES

Provide Name, address & telephone number of Hospital / Clinic :

Treating Doctor's Name & Qualification

Treating Doctor's Telephone Number : (O) (M)

Room / Ward / Bed Number :

Date of Treatment : From

DD / MM / YYYY

To :

DD / MM / YYYY

Date of onset of symptoms:

DD / MM / YYYY

Attending Doctor's Report

Date doctor contacted :

Time : HH : MM

Nature of Ailment :

State diagnosis and nature of treatment provided :

When did patient's symptoms first appear ?

Describe any other disease or infirmity affecting present condition :

Was the ailment due to Pregnancy : ☐ Yes ☐ No

Was the ailment aggravated due to any pre-existing condition ? ☐ Yes ☐ No

If yes, please give details :

Medical Treatment Expenses Details :

Sr. No.	Details of Medical treatment/Medical evacuation / expenses	Date	Expenses in Foreign Currency / INR
1.	Hospital Bill	DD / MM / YYYY	
2.	Medical Bills	DD / MM / YYYY	
3.	Others (Please Specify)	DD / MM / YYYY	
4.	Others (Please Specify)	DD / MM / YYYY	
5.	Others (Please Specify)	DD / MM / YYYY	
	Total		

Documents to be submitted in support of the claim:

- Medical reports and discharge summary issued by the Hospital furnishing the name of the Insured, period of treatment, details of treatment rendered.
- Bills/receipts for :
 - Charges paid towards Hospital accommodation, nursing facilities and other medical services rendered;
 - Fees paid to the Medical Practitioner, special nursing charges, etc.
 - Charges incurred towards any and all test and/or examinations rendered in connection with the treatment
 - Charges incurred towards medicines or drugs purchased from outside duly supported by the prescriptions of the Medical Practitioner attending on the insured.
- Any other additional document as required by Insurer.

ANNEXURE IV - EN-ROUTE ACCIDENTAL HOSPITALIZATION EXPENSES-COMMON CARRIER

Provide Name, address & telephone number of Hospital / Clinic :

Treating Doctor's Name & Qualification

Treating Doctor's Telephone Number : (O) (M)

Room / Ward / Bed Number :

Date of Treatment : From

DD / MM / YYYY

To :

DD / MM / YYYY

Date of onset of symptoms:

DD / MM / YYYY

Attending Doctor's Report

Date doctor contacted :

Time : HH : MM

Nature of Ailment :

State diagnosis and nature of treatment provided :

When did patient's symptoms first appear ?

Describe any other disease or infirmity affecting present condition :

Was the ailment due to Pregnancy : ☐ Yes ☐ No

Was the ailment aggravated due to any pre-existing condition ? ☐ Yes ☐ No

If yes, please give details :

ANNEXURE IV - EN-ROUTE ACCIDENTAL HOSPITALIZATION EXPENSES-COMMON CARRIER (CONTD.)

Medical Treatment Expenses Details :

Sr. No.	Details of Medical treatment/Medical evacuation / expenses	Date	Expenses in Foreign Currency / INR
1.	Hospital Bill	/ /	
2.	Medical Bills	/ /	
3.	Others (Please Specify)	/ /	
4.	Others (Please Specify)	/ /	
5.	Others (Please Specify)	/ /	
	Total		

Documents to be submitted in support of the claim:

1. Medical reports and discharge summary issued by the Hospital furnishing the name of the Insured, period of treatment, details of treatment rendered.
2. Bills/receipts for :
 - a. Charges paid towards Hospital accommodation, nursing facilities and other medical services rendered;
 - b. Fees paid to the Medical Practitioner, special nursing charges, etc.
 - c. Charges incurred towards any and all test and/or examinations rendered in connection with the treatment
 - d. Charges incurred towards medicines or drugs purchased from outside duly supported by the prescriptions of the Medical Practitioner attending on the insured.
3. Any other additional document as required by Insurer.

ANNEXURE V - DOMESTIC OPD EXPENSES

Incident details

Dates of Treatment From / / To / /

Date of onset of Symptoms / / [illegible]

Address _____

[illegible]

Documents to be submitted in support of the claim:

1. OPD consultation bill
2. Prescription / consultation paper
3. Diagnostic test reports (if any)
4. Proof of travel for the Trip (ticket / boarding pass / itinerary / cab receipt / reservation document)
5. NEFT details
6. KYC number
7. Any other document as may be appropriately applicable for this Cover.

ANNEXURE VI - EN-ROUTE OPD EXPENSES- COMMON CARRIER

Mode of Travel (as selected in Policy Schedule):

Incident details All modes Flight Train/Cab/Taxi/Water Transport

[illegible]

Dates of Treatment From / / To / /

Date of onset of Symptoms D | D | / M | M | / Y | Y | Y | Y |

Provider Name

Address _____

Contact No. _____

ANNEXURE VI - EN-ROUTE OPD EXPENSES- COMMON CARRIER (CONTD.)

Documents to be submitted in support of the claim:

1. OPD consultation bill
2. Prescription / consultation paper
3. Investigation reports
4. Proof of travel for the Trip (ticket / boarding pass / itinerary / cab receipt / reservation document)
5. NEFT details
6. KYC number
7. FIR / Police report (only if accident required legal reporting)
8. Any other document as may be appropriately applicable for this Cover.

ANNEXURE VII - DOMESTIC LOSS OF BAGGAGE & PERSONAL EFFECTS

Date of Loss: / /

Incident Details: (Please state how, when, and where the loss occurred. Mention theft / burglary / larceny / robbery / mugging details.)

Place of Loss:

Were the authorities notified? ☐ YES ☐ NO

If Yes, mention name of authority (police / hotel / accommodation / service provider):

Acknowledgement of Loss (from hotel / service provider / accommodation / police):

List of Items Lost: (If space is insufficient, attach a separate sheet.)

Estimated Value of Items:

Documents to be submitted in support of the claim:

1. **Police Report / FIR / Panchnama** wherever applicable.
2. **Acknowledgement of loss** from hotel / accommodation / service provider.
3. **Purchase bills / invoices** for items valued above the limits specified under the Policy.
4. **Travel proof** (ticket / boarding pass / itinerary) confirming the insured was on a Trip.
5. **NEFT details.**
6. **KYC documentation** (where applicable).
7. Any other document as may be appropriately required under this Cover.

Claimant's/Insured's Signature: _____

Date: DD / MM / YYYY Place: _____

ANNEXURE VIII - THEFT / BURGLARY OF HOME CONTENTS

Address of property where loss was sustained:

Date of Loss: / /

Cause of Loss (Incident details): (Please describe how, when and where the theft/burglary took place. Include details of any forced entry.)

Exact description of nature of loss and circumstances:

Items lost or damaged: (If additional space is required, attach a separate sheet.)

Documents to be submitted in support of the claim:

1. **FIR or Police Report** filed immediately after the incident.
2. **Panchnama / Investigation report**, if issued by authorities.
3. **Proof of ownership/value** of stolen items (bills, invoices, photographs, or bank statements where applicable).
4. **Estimate and final bills** for repair or replacement (if applicable).
5. **Proof of travel** during the Trip (ticket / boarding pass / itinerary), establishing that the Insured was away from residence at the time of loss.
6. **NEFT details and KYC number**.
7. Any other document as may be required for assessment under this Cover.

Claimant's/Insured's Signature: _____

Date: / /

Place:

ANNEXURE IX - MISSED CONNECTION

Contingency / Reason for Missed Connection:

Transport Details – Prior Segment (Flight / Train)

Type of Transport: ☐ Flight ☐ Train

Name of Carrier:

Transport Number (Flight No. / Train No.):

Scheduled Arrival Time: / / :

Actual Arrival Time: / / :

Reason for Delay of the Previous Flight / Train:

- ☐ Inclement Weather
- ☐ Strike / Job Action
- ☐ Equipment Failure
- ☐ Technical Instructions / Operational Hold
- ☐ Act of Terrorism
- ☐ Other (please specify): _____

Connection Details – Missed Segment (Flight / Train)

Type of Connecting Transport: ☐ Flight ☐ Train

Connecting Carrier Name:

Connecting Transport Number (Flight No. / Train No.):

Scheduled Departure Time (Missed Segment): / / :

Expenses Due to Missed Connection

Refund / No Show Documentation from Carrier Attached?	YES	NO
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Supporting Bills / Receipts Attached? | YES | NO

1. Confirmation of delay from the airline or railway operator stating scheduled and actual arrival times and reason for delay.
2. **Ticket / Boarding Pass / Travel proof** for the preceding flight/train.
3. Unused ticket for the missed connecting flight/train with cancellation / no show endorsement.
4. Refund / no show document issued by the airline / IRCTC / operator.
5. Original used ticket & boarding pass for alternate travel with fare paid.
6. **Initial itinerary / schedule** showing planned connection times (mandatory for gap validation).
7. NEFT details.
8. KYC details (where applicable).
9. Any other document reasonably required for claim assessment.

Claimant's/Insured's Signature:

Date: DD / MM / YY YY Place: |

☐ Trip Cancelled / ☐ Trip Interrupted ☐ Also claiming for Trip Regained (Tick whichever appropriate)[illegible]





























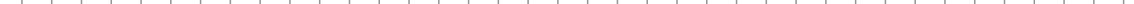
[illegible][illegible]

Please detail out the above reason for trip cancellation / interruption (how, where, when and reason for the same) :

Trip Cancellation / Interruption date D | D | / M | M | / Y | Y | Y | Y |

Original Travel Dates : From / / To : / /

Person Affected and Relationship with the Insured : (If not the insured, please also provide address and contact details)

[illegible]

Details of Losses / Expenses Incurred :

Details of Losses / Expenses Incurred :

Sr. No.	Loss / Expenses Details	Amount
	(Please Write Here)	(Please Write Here)
	(Please Write Here)	(Please Write Here)
	(Please Write Here)	(Please Write Here)
	(Please Write Here)	(Please Write Here)
		Total :

Documents to be submitted in support of the claim :

1. In case of cancellation of the Trip either in the City of Residence of the Insured or any other intermediate place forming part of the Trip by the Common Carrier solely resulting from contingencies namely Earthquake, Storm, Flood, Inundation, cyclone, tempest & Terrorism, fog (if specifically covered) duly completed claims form to be accompanied by :
 - a. Confirmation of cancellation of the Trip from the Common Carrier detailing the circumstances of cancellation;
 - b. Original used air ticket indicating the cost the ticket and receipt for the refund of the fare of the Common Carrier towards the cancelled portion of the Trip the Cancellation charges retained;
 - c. Original bill and a receipt/letter obtained from the hotel and /or guest house and/or any other paid residential accommodation (available for fee) indicating the amount paid for the accommodation, the refund given and the cancellation charges retained, wherever such accommodation has be arranged at the place of cancellation of the Trip;
 - d. Used air ticket in original for return journey from the place of cancellation to the City of residence of the Insured which indicate the cost of the tickets together with the receipts for the refunds obtained towards the unfulfilled portion of the Trip.

ANNEXURE X - DOMESTIC TRIP CANCELLATION AND INTERRUPTION (CONTD.)

2. In case the cancellation of the Trip shall result because of personal contingencies covered hereunder or a decision taken at the instance of the Insured arising out of the contingencies namely Earthquake, Storm, Flood, inundation, cyclone, tempest & Terrorism, fog (if specifically covered) the duly completed claims form to be accompanied by :
 - a. A declaration from the Insured furnishing the circumstances that compelled him/her to cancel the Trip;
 - b. Medical evidence as may be required by the Third Party Administrator in case of the cancellation of the Trip arising out of personal contingencies of the Insured or his/her Immediate Family;
 - c. Receipt for the refund of the fare of the Common Carrier towards the cancelled portion of the Trip indicating the cancellation charges retained;
 - d. Receipt/letter obtained from the for the hotel and /or guest house and/or any other residential accommodation (available for a fee) indicating the cancellation charges retained, wherever such accommodation has been arranged at the place of cancellation of the Trip;
 - e. Used air ticket or boarding pass in original for return journey from the place of cancellation to the City of Residence of the Insured together with the receipts for the refunds obtained towards the unfulfilled portion of the Trip.
3. In case the cancellation charges either for the Trip or part of it or in relation to the accommodation in a hotel/guest house/other residential accommodation is waived to the advantage of the Insured subsequent to any settlement of claim under this Benefit, the Insured shall forthwith return the sum paid by the Company to the extent of such waiver.

ANNEXURE XI - DOMESTIC LOSS OF CHECKED IN BAGGAGE

Describe when & where the Loss / Delay took place :

State the extent of Delay / Loss : (In hrs)

Place of Delay / Loss

Name the common carrier :

No. of Hours of bag delay

Flight Details :

1. Flight No. :

From

To :__

2. Flight No. :

From

To : _____

Actual Date & Time of Arrival of flight at Port :

D J D

/ M J M

/ Y J

Y Y

H

H

Actual Date & Time when Bags were delivered

D J D

/ M J M

/ Y J

Y Y

И

Had the common carrier been notified at the time of loss ? Yes ☐ No ☐ (Tick the appropriate)

Property Irregularity Report (PIR) number from Airline/Common Carrier :

Details of compensation required from carrier

Details of items purchased / lost / expenses.

Sr. No.	Item Purchased / Items Lost	Date of Purchase	Cost in Foreign Currency (In INR for loss claim)
	(Please Write Here)	<u> </u> <u> </u> / <u> </u> <u> </u> / <u> </u> <u> </u> <u> </u> <u> </u>	(Please Write Here)
	(Please Write Here)	<u> </u> <u> </u> / <u> </u> <u> </u> / <u> </u> <u> </u> <u> </u> <u> </u>	(Please Write Here)
	(Please Write Here)	<u> </u> <u> </u> / <u> </u> <u> </u> / <u> </u> <u> </u> <u> </u> <u> </u>	(Please Write Here)
	(Please Write Here)	<u> </u> <u> </u> / <u> </u> <u> </u> / <u> </u> <u> </u> <u> </u> <u> </u>	(Please Write Here)
	(Please Write Here)	<u> </u> <u> </u> / <u> </u> <u> </u> / <u> </u> <u> </u> <u> </u> <u> </u>	(Please Write Here)
			Total :
			Compensation From Airlines :
			Net Amount :

Documents to be submitted in support of the claim for Checked-in Baggage Loss :

1. Statement of claim furnishing the details of items contained in the Checked-in Baggage.
2. Property irregularity report issued by the Common Carrier.
3. Voucher of the Common Carrier for the compensation paid for the non-delivery/short delivery of the Checked-In Baggage.
4. Copies of correspondence exchanged, if any, with the Common Carrier in connection with the non-delivery/short delivery of the Checked-in Baggage.

In case of compensation from the Common Carrier having been received after payment of the claim by the company hereunder, the Insured shall repay to the Company such amount in excess of his/her loss after taking into account the amount of claim received from the Company and at that received from the Common Carrier. In case the undelivered Checked-in Baggage is subsequently traced by the Common Carrier and offered for delivery to the Insured, the Insured shall take delivery of the Checked-in Baggage and refund the amount paid by the Company hereunder. In case of delivery of part of the Checked-In Baggage, the amount paid by the Company attributable to such Checked-In Baggage shall be refunded by the Insured to the Company.

Documents to be submitted in support of the claim Checked-In Baggage Delay :

1. Property irregularity report stating the scheduled time delivery and actual time of delivery of the Checked-In Baggage issued by the Common Carrier;
2. Voucher of the Common Carrier for the compensation paid for the delay in delivery of the Checked-In Baggage;
3. Copies of correspondence exchanged, if any, with the Common Carrier in connection with the delay in delivery of the Checked-In Baggage.
4. Any additional documents as required by the Insurer.

ANNEXURE XIII - DOMESTIC FLIGHT DELAY – FIXED BENEFIT (CONTD.)

Delay Reason (as confirmed by airline):

- ☐ Operational delay
☐ Weather
☐ Technical reason
☐ Crew / staff unavailability
☐ Other (specify):

Incident Details (Narrative): (Please describe how, when and where the delay occurred.)

Documents to be submitted in support of the claim:

1. **Confirmation of delay** issued by the airline or verified through an approved aviation status source.
2. **Ticket and Boarding Pass** for the delayed flight.
3. **Stamped boarding pass** (if available).
4. **NEFT details** for benefit payout.
5. **KYC number** (if applicable).
6. Any other document as may be appropriately required under this Cover.

Claim Amount (as per fixed benefit chosen in Policy Schedule):

Claimant's/Insured's Signature:

Date: D | D | / M | M | / Y | Y | Y | Y | Place: |

ANNEXURE IV - DOMESTIC AIRLINE-OPERATED CANCELLATION BENEFIT

Incident Details: (Please describe how, when and where the flight cancellation occurred.)

Flight Details:

Airline Name:

[illegible]

PNR Number:

Scheduled Date & Time of Departure: D | D | / M | M | / Y | Y | Y | Y | H | H | : M | M |

Cancellation Date & Time (as confirmed by airline): DD/ MM/ YYYY HH:MM

Reason for Cancellation (as per airline communication):

- ☐ Operational
☐ Weather
☐ Technical
☐ Crew/Staff Scheduling
☐ Other (please specify):

Refund / No Show / Rebooking Details

Refund / No Show Document Attached: | YES | NO

Amount Refunded / Forfeited:

Was the customer re accommodated by the airline on another flight? | YES | NO

If Yes, Rebooked Flight Number:

Rebooked Departure Date & Time: D | D | / M | M | / Y | Y | Y | Y | H | H | : M | M |

ANNEXURE IV - DOMESTIC AIRLINE-OPERATED CANCELLATION BENEFIT (CONTD.)

Documents to be submitted in support of the claim:

1. **Confirmation of cancellation** issued by the airline.
2. **Ticket and boarding pass** (if boarding pass was issued).
3. **Refund / no show documentation** issued by the airline.
4. **Flight status verification** (CIRIUM/airline website snapshot acceptable until API integration).
5. **NEFT details**.
6. **KYC number** (where applicable).
7. Any other document as may be appropriately applicable for assessment of this Cover.

Claimant's/Insured's Signature: _____

Date: / /

Place:



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

ALL CLAIM SETTLEMENTS SHOULD BE MADE THROUGH NEFT (AS PER IRDA CIRCULAR), PLEASE PROVIDE YOUR BANK ACCOUNT DETAILS.

1. **Patient's Name:** _____
(in respect of whom claim is made):
2. **Policy Number:** _____
3. **Card No./ UHID No.:** _____
4. **Group/Company Name** (for Group/Corporate policy holders): _____
5. **Claim Number** (if allotted): _____
6. **Mobile/ Contact No.:** _____
7. **Email:** _____
8. **As per IRDA Circular No.: IRDA/F&A/CIR/GLD/056/02/2014, Proposer's/ policy holder's bank account details are mandatory to process the claim through EFT.**

Please provide ANY ONE of the below documents of proposer/ policy holder-

- ☐ Please provide a self-attested copy of a valid Identity proof of the Proposer/Policy holder (provide any of the mentioned documents in Proof of Identity under Part-D)
- ☐ Cancelled cheque copy
- ☐ Bank attested copy of Passbook with IFSC code

9. Please provide the below details (all fields are compulsory)

- Proposer (policy holder)/ Employee name* (as per bank records): _____
- Proposer/ policy holder 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)
- PAN no. of Proposer: _____

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

For Retail policy, Name & Account details of Proposer required. For Corporate policy, Employee Name & Account details required.

Terms and Conditions for Payments through RTGS/ NEFT

1. The details provided by the Proposers/ policy holder in the Mandate Form 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 Proposer(s)/ policy holder 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 Proposer/ policy holder agrees that under the RTGS/ NEFT facility, there may be a risk of non-payment in the Proposer/ policy holder Accounts No. 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 Proposer/ policy holder 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 Proposer/ policy holder 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 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 Proposer/ policy holder will be acknowledged through a confirmation letter by ICICI Lombard General Insurance Company Ltd. In no case can the Proposer/ policy holder construe his termination notice as effective unless a confirmation has been provided by ICICI Lombard to the Proposer/ policy holder stating the date of receipt of such communication by the Proposer/ policy holder.
7. The Proposer/ policy holder agrees that transaction(s) through RTGS/ NEFT facility may attract inward RTGS/ NEFT charges, which if levied by the Proposer's/ policy holder's bank, shall be borne by the Proposer/ policy holder only.
8. ICICI Lombard has the absolute discretion to amend or supplement any Terms and Condition stated herein at any time and will endeavor 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 Proposer/ policy holder 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 the company.
10. Notices under these Terms and Conditions may be given in writing by delivering them by hand or e-mail or on ICICI Lombard General Insurance Company Ltd. website www.icicilombard.com or by sending them by post to the last address of the Proposer/ policy holder.
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.
12. I/We further 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 the knowledge of the Proposer/ policy holder 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 Proposer/ policy holder.

Account holder's Signature

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.
 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.

To be filled by Proposer: Application Type* ☐ New ☐ Update

KYC Number (Mandatory for KYC update request)

If KYC Number is not available, please fill this Central-KYC (C-KYC) form

☐ 1. PERSONAL DETAILS (Please refer instruction A at the end)

	Prefix	First Name	Middle Name	Last Name
☐ Name* (Same as ID proof)				
Maiden Name (If any*)				
Father / Spouse Name*				
Mother Name*				
Date of Birth*				
Gender*	☐ M- Male	☐ F- Female	☐ T-Transgender	
Marital Status*	☐ Married	☐ Unmarried	☐ Others	
Citizenship*	☐ IN- Indian	☐ Others (ISO 3166 Country Code)		
Residential Status*	☐ Resident Individual	☐ Non Resident Indian	☐ Person of Indian Origin	
Occupation Type*	☐ S-Service (☐ Private Sector	☐ Public Sector	☐ Government Sector)	
	☐ O-Others (☐ Professional	☐ Self Employed	☐ Retired ☐ Housewife ☐ Student)	
	☐ B-Business			
	☐ X- Not Categorised			

PHOTO



Signature / Thumb Impression

☐ 2. TICK IF APPLICABLE ☐ RESIDENCE FOR TAX PURPOSES IN JURISDICTION(S) OUTSIDE INDIA (Please refer instruction B at the end)

ADDITIONAL DETAILS REQUIRED* (Mandatory only if section 2 is ticked)

ISO 3166 Country Code of Jurisdiction of Residence*

Tax Identification Number or equivalent (If issued by jurisdiction)*

Place / City of Birth* ISO 3166 Country Code of Birth*

☐ 3. PROOF OF IDENTITY (PoI)* (Please refer instruction C at the end)

(Certified copy of any one of the following Proof of Identity[PoI] needs to be submitted)

☐ A- Passport Number		Passport Expiry Date	
☐ B- Voter ID Card			
☐ C- PAN Card			
☐ D- Driving Licence		Driving Licence Expiry Date	
☐ E- UID (Aadhaar)			
☐ F- NREGA Job Card			
☐ Z- Others (any document notified by the central government)		Identification Number	
☐ S- Simplified Measures Account - Document Type code		Identification Number	

4. PROOF OF ADDRESS (PoA)*

☐ 4.1 CURRENT / PERMANENT / OVERSEAS ADDRESS DETAILS (Please see instruction D at the end)

(Certified copy of any one of the following Proof of Address [PoA] needs to be submitted)

Address Type*	☐ Residential / Business	☐ Residential	☐ Business	☐ Registered Office	☐ Unspecified
Proof of Address*	☐ Passport	☐ Driving Licence	☐ UID (Aadhaar)	☐ Others	
	☐ Voter Identity Card	☐ NREGA Job Card			
	☐ Simplified Measures Account - Document Type code				

Address

Line 1*

Line 2

Line 3

District* Pin / Post Code* State / U.T Code* ISO 3166 Country Code*