

Claim Form - Universal Protection Insurance Policy

Name of the Insured (Policy Holder) _____

Customer ID Policy Number Policy Number to Sum Insured

Address for communication _____

_____ City _____

Pincode _____ State _____

Contact No. _____ E-mail _____

Name of the Insured (Claimant) _____

Relationship with the Insured _____

Age _____ Occupation _____

SECTION-I CRITICAL ILLNESS CLAIM

Date on which injury is sustained or disease / illness is first detected

Please describe injury sustained or disease / illness contacted (including cause)

Name of the Attending Medical Practitioner Dr. _____

Address _____

_____ City _____

Pincode _____ State _____

Contact No. _____ E-mail _____

Registration No. _____

Name of the Hospital / Nursing Home _____

Address _____

_____ City _____

Pincode _____ State _____

Telephone No. _____ Fax No. _____

Date of Admission

D	D	M	M	Y	Y	Y	Y
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Date of Discharge

D	D	M	M	Y	Y	Y	Y
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Date of Intimation to Bharti AXA General Insurance Co. Ltd

D	D	M	M	Y	Y	Y	Y
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Mode of Intimation to Bharti AXA General Insurance Co. Ltd.

If you have not intimated the Bharti AXA General Insurance Co. Ltd., please provide reasons for the same.

Are you currently covered under any other insurance like Personal Accident, Critical Illness, Mediclaim (Individual or Group), Health Insurance, etc. ☐ Yes ☐ No

a. Policy Type

b. Policy No.

c. Policy Period

d. Insurance Company

Has there previously been any claim under this policy? ☐ Yes ☐ No

If yes, please give previous claim number and details of claim?

Details of expenses incurred. Please refer to your Policy Schedule for coverage details. In case the space provided is insufficient, please attach an additional sheet.

Insured Declaration:

I/We declare that, in respect of the above treatment, no benefits are receivable under any other medical scheme of insurance.

I/We hereby warrant the truth of the foregoing particulars in every respect and I/We agree that if I/We have made or shall make any false or untrue statement, suppress or conceal information, my right to claim reimbursement of the said expenses shall be absolutely forfeited.

I /We also consent and authorize the Company to seek medical information from any hospital/ medical practitioner who has at any time attended on me. I/We authorize the Company to make payment of claim admissible as per terms, conditions and limitations of the Policy to the Hospital on my behalf for full and final settlement of hospital bills.

I/We hereby authorize any hospital, physician, or other person who has treated attended or examined me/us, to furnish to the Company, or its authorized representative, any and all information with respect to any illness or injury, medical history, consultation, prescriptions or treatment and copies of relevant hospital or medical records. A photocopy of this authorization shall be as effective and valid as the original.

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

Date:

D	D	M	M	Y	Y	Y	Y
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Place: _____

Checklist of Documents to be enclosed:

1. Claim form duly signed along with attending physician statement.
2. Discharge summary wherever applicable.
3. Hospital final bill wherever applicable.
4. Attending Surgeon's/Physician's Prescription advising hospitalization wherever applicable.
5. Diagnostic reports with doctor's prescription.
6. Investigation test reports and payment receipts.

Attending Physician's Statement:

Please give complete answers to all questions. (To be filled in case discharge summary doesn't contain the following information)

Name of Insured Person (Claimant)

Age

Address

City

Pincode

State

Contact No.

E-mail

Nature of disease suffered Insured Person _____

What treatment was given / operation performed, if any? _____

When did the first symptom appear? _____

Is the present ailment pre-existing or caused by any pre-existing ailment? ☐ Yes ☐ No

If yes, please give details. _____

Signature of the Physician:

Name of Doctor _____
_____ Age _____

Registration No.

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Address _____

_____ City _____

Pincode _____ State _____

Contact No. _____ E-mail _____

SECTION II-PERSONAL ACCIDENT

Details of Accident

Name of the Insured Person died/ injured in the accident _____

Relationship with the employee/ member _____

Employee/member identification no. _____

Date of the Accident

D	D	M	M	Y	Y	Y	Y
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 Time of the Accident

0	0
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0	0
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Where it happened _____

Name of the Witness _____

Address _____

_____ City _____

Pincode _____ State _____

Contact No. _____ E-mail _____

How did the Accident occur? _____

Nature of Injury received (if to limb or Eye state whether right or left) _____

Nature of disablement _____

Extent of disablement _____

Name of Medical Practitioner in attendance _____

Address _____

_____ City _____

Pincode _____ State _____

Where and when can a Medical Officer of our Company visit you, if necessary _____

Are you insured in any other Office or Offices granting compensation for accident? _____

If so state name and address of company or companies and amount of insurance _____

Insured Declaration:

I/We hereby declare that the foregoing statements are true in all respects and that I/We have not attempted to conceal from the Company anything with which it ought to be made acquainted and also that if I/We 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/our right to compensation forfeited and am/are 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/We may make in connection with this claim.

Signature of the Insured

Date

D	D	M	M	Y	Y	Y	Y
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Address _____

MEDICAL CERTIFICATE

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

Name of the Insured (Claimant) _____
_____ Age _____

Nature and cause of Accident _____

If to eye or limb, state left or right. ☐ Left ☐ Right

Whether the appearance of the injuries are consistent with the account given of the accident.

Date on which you first attended claimant for this injury.

D	D	M	M	Y	Y	Y	Y
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Has claimant been totally prevented from attending to any portion of his business? If so for how long?

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.

Present condition. _____

How long from the happening of the Accident do you consider? _____

- ☐ Total disablement will last
☐ Partial disablement will last

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: _____

Checklist of Documents to be enclosed:

1. First Information Report and Final Police report, from police authorities wherever necessary (in case of accidents outside residence)
2. Death Certificate from the Municipal Authorities
3. Post Mortem Report
4. All reasonable information, assistance and proofs in connection with any claim in this section
5. Investigation Reports like Laboratory test, X-rays and reports essential of confirmation of the Injury etc.
6. Disability certificate from a Doctor or hospital confirming the extent and nature of disability
7. Proof satisfactory to the Company shall be furnished in connection with all matters upon which a claim is based. Any medical or other agent of the Company shall be allowed to examine the Insured person on the occasion of any alleged Injury when and as often as the same may reasonably be required on behalf of the Company. Such evidence as the Company may from time to time require shall be furnished and a post-mortem examination report wherever applicable, shall be furnished to the Company within a period of thirty days
8. Any other documents as may be required to establish the admissibility of a claim under this section.

SECTION III - INVOLUNTARY LOSS OF JOB

Name of the Employer of Insured _____

Address _____

City _____

Pincode _____ State _____

Date of Employment

D	D	M	M	Y	Y	Y	Y
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 Date of Termination

D	D	M	M	Y	Y	Y	Y
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Reason of Termination _____

Period of Termination (In case of Temporary Termination) _____

No of EMI Paid _____ No of EMI Outstanding _____

Insured Declaration:

I/We hereby declare that the foregoing statements are true in all respects and that I/We have not attempted to conceal from the Company anything with which it ought to be made acquainted and also that if I/We 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/our right to compensation forfeited and am/are 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/We may make in connection with this claim.

Signature of the Insured

Date

D	D	M	M	Y	Y	Y	Y
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Address _____

Checklist of Documents to be enclosed:

1. Duly completed claim form;
2. Certificate if applicable from the Bank stating the amortization schedule, the EMI Amounts, Principal Outstanding, etc.
3. Certificate from the employer of the Insured confirming the termination, dismissal, temporary suspension or retrenchment from employment of the Insured furnishing the date of termination, dismissal, temporary suspension or retrenchment from employment of the Insured with the reasons for the same. In case of temporary suspension the period of suspension should also be mentioned in such certificate.
4. Appointment letter
5. Last 3 Months Salary Slip
6. Any other document as required by the Company to investigate the Claim or Our obligation to make payment for it.

SECTION IV – HOME (SFSP & BURGLARY)

Particulars of Accident/Damage:

Date of Occurrence

D	D	M	M	Y	Y	Y	Y
---	---	---	---	---	---	---	---

 Time of Occurrence

0	0
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0	0
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Brief description of the Occurrence _____

When did you first come to know of the accident? _____

When the claim was first notified to the Insurer? _____

Approximate value of loss _____

Whether the loss is intimated to

Police ☐ Fire Brigade ☐

Please give details of other insurances, if any, covering present loss _____

Please give details of previous claims, if any, on affected this Section of the Policy _____

Insured Declaration:

I/We hereby declare that the above questions have been conscientiously and faithfully answered and would be liable for the correctness and completeness of the statements.

Signature of the Insured

Date

D	D	M	M	Y	Y	Y	Y
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Address _____

Checklist of Documents to be enclosed:

1. Duly completed Claim form
2. Copy of FIR
3. Estimate of loss / repairs
4. Invoice/ Bills/Receipts
5. Any other details/documents called for a specific loss



ICICI Lombard General Insurance Company Limited

Mailing Address: Interface Building No. 16, 601-602, 6th Floor, New Link Road, Malad (West), Mumbai - 400 064.

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

Visit us at www.icicilombard.com • **Mail us at** customersupport@icicilombard.com • **Toll Free No.:** 1800 2666 • **Chargable No.:** +91 86 55 222 666

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