

NOTE

- ★ To be filled in CAPITAL letters only
- ★ Seperate claim form to be filled for every insured person for redemption
- ★ As per IRDA, all claims shall be settled in electronic mode only. Please provide correct bank account details

Part - A (Insured Details)

1. Name of Policy holder/Proposer*:

Current Policy number:

Card No./UHID:

2. Claimant Details:

Name of Insured:

Relationship with the Policy holder : Present completed age (in years) : Gender : M F T

Current Residential address:

City: State:

Pin Code: Mobile No.: Landline No.:

E-mail:

Part - B (Claim Details)

Nature of expense	Bill Number	Date						Amount (in ₹)			
1.		D	D	M	M	Y	Y				
2.		D	D	M	M	Y	Y				
3.		D	D	M	M	Y	Y				
4.		D	D	M	M	Y	Y				
Total Claimed Amount* (In ₹)											

*Please provide original bills

Part - C - (EFT Details)

1. Name of Policy holder/Proposer*:

2. Bank account number of Policy holder/Proposer:

3. Name of the Bank:

4. Branch Name:

5. IFSC of the Bank: (should be same as per the provided cheque leaflet)

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

EFT DETAILS : Provide any ONE of the below (Mandatory)

☐ Cancelled cheque copy/ ☐ Valid photo identity proof (self attested)/ ☐ Bank attested copy of passbook with IFSC

ENCLOSURE CHECKLIST : Note: All bills/documents should be in original

☐ Claim form duly filled & signed ☐ Investigation bills ☐ Investigation reports ☐ Hospitalization bills

☐ Medicine bills ☐ Doctor prescription ☐ Any other documents (Please specify) _____

DECLARATION

I hereby agree, affirm and declare that

- The statements / information given / stated in this claim form are true, correct and complete to the best of my knowledge and belief.
- No material information which is relevant to the processing of the claim or in any manner has a bearing on the claim has been withheld or not disclosed.
- If I 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 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 an admission of claim liability by the company and the company reserves the right to process or reject or require further/additional information in respect of the claim.
- I also consent and authorize ICICI Lombard Health Care to seek medical information from any hospital/medical practitioner who has any time attended on the insured person.
- I hereby declare that I have included all the bills / receipts for the purpose of this claim & that I will not be making any supplementary claim.
- I confirm that the expenses for which claim is being lodged have been incurred in respect of the insured.

Place : _____

Date : / /

Signature of Claimant/ Proposer _____