ICICI Lombard Health Insurance

Wellness Reward Points Accumulation (OPD) Form

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

ICICI Lombard Health Care

NOTE

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

1. **Name of Policy Holder/Proposer:**
   Current Policy Number:
   Card No./UHID:

2. **Details of the insured person in respect of whom points to be considered:**
   Name of Insured:
   Relationship with the Policy Holder : Present completed age (in years) : Gender : M F
   Current Residential address:
   City: State:
   Pin Code: Mobile No.: Landline No.:
   E-mail:

3. **Details of the bills/receipts to be attached:**

Activity Heads/ Bills (As applicable)	**Bill No.**	**Bill Date**	**Bill attached**	**Name of Hospital/Diagnostic cente/ Event organiser/ other**
Heart related screening tests (under PRA#) above 45 years		D D M M Y Y	Y N	
HbA1c/ Complete lipid profile (under PRA#) any age		D D M M Y Y	Y N	
PAP Smear (under PRA) Females*		D D M M Y Y	Y N	
Mammogram (under PRA) Females*		D D M M Y Y	Y N	
Prostate Specific Antigen (PSA) (under PRA) Males**		D D M M Y Y	Y N	
Any other test as suggested by Our empanelled Medical expert (under PRA)		D D M M Y Y	Y N	
Gym/ Yoga membership for 1 year		D D M M Y Y	Y N	
Participation in Professional sporting events like Marathon/ Cyclothon/ Swimathon, etc.		D D M M Y Y	Y N	
Participation in any other health & fitness activity/ event organized by ICICI Lombard		D D M M Y Y	Y N	

4. ☐ Quit smoking- based on self declaration
   ☐ Share your fitness success story
   ☐ On winning any health quiz organized by ICICI Lombard

   Please share details

PRA refers to Preventive Risk Assessment ** Males above age 45 * Females above age 45

DECLARATION

I hereby agree, affirm and declare that

a) The statements / information given / stated in this claim form are true, correct and complete to the best of my knowledge and belief.
b) 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.
c) 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.
d) The receipt of this bills/receipts/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 bills/receipts.
e) 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.
f) 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.
g) I confirm that the expenses for which claim is being lodged have been incurred in respect of the insured.

Place :_____ Date : D D / M M / Y Y Y Y

_____
Signature of Claimant/ Proposer

016339CF/SC

Claim documents to be dispatched to: ICICI Lombard Healthcare, ICICI Bank Tower, Plot No. 12, Financial District, Nanakram Guda, Gachibowli, Hyderabad-500032