

## ICICI Lombard Health Care Claim Form - Hospitalization

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

### Overview Health Claim Form - Hospitalization

Part A		To be filled	Requirement
A1	Type of Claim- To be filled by Insured	By insured/ insured relatives	To track the policy and other details of the insured
A2	Details of the insured person-To be filled by Insured		
A3	Available in Policy Copy/ Employee details		
A4	Available in Policy Copy		
A5	Available in Discharge Summary		
A6	Other policy coverages		
A7	Currently covered by any other mediclaim		
A8	Available in Hospital Bills/ Self Declaration		
A9	Available in Hospital Bills		
A10	Checklist		
A11	Reason of delay-To be filled by Insured		
Page end	Self Declaration		
Part B			
B1	Hospital Details	To be filled by Hospital/ Treating doctor	To track the hospital details and the treatment details related to the patient admission
B2	Doctor Details		
B3	Patient details		
B4	Treatment / Procedure Details		
B5	Required only for Retail/ Individual customers		
Page end	Hospital declaration		
Part C			
C1	EFT Details	Copy of cancelled cheque/Copy of passbook	bank statement with Payee/account holders name and IFSC code
C-KYC No.	Part D (Only for Retail/ Individual customers if claiming > ₹ 1 lakh)		
Yes	Please provide, if Central KYC (C-KYC) no. available: <u>          {C_KYC_ID}          </u>	To be filled by Insured	As per IRDA, C-KYC is mandate for claims greater than ₹ 1 lakh
No	Please fill the C-KYC form		

### Documents Submitted

S.No.	Document	Yes	No	Type of document
1.	Claim form duly filled	<u>{DOC_CLAIM_FORM_DI}</u>	<u>{DOC_CLAIM_FORM_DI}</u>	Original
2.	Discharge Summary/ Daycare Summary	<u>{DOC_DISCHARGE_SUM}</u>	<u>{DOC_DISCHARGE_SUM}</u>	Original
3.	ICICI Lombard Health card	<u>          Y          </u>	<u>          N          </u>	Original
4.	Final Hospital Bill	<u>{DOC_FINAL_HOSPITAL}</u>	<u>{DOC_FINAL_HOSPITAL}</u>	Original

5.	Payment Receipts	{DOC_PAYMENT_RECE}	{DOC_PAYMENT_RECE}	Original
6.	Investigation Reports	{DOC_INVESTIGATION}	{DOC_INVESTIGATION}	Original
7.	Pharmacy Bills	{DOC_PHARMACY_BILL}	{DOC_PHARMACY_BILL}	Original
8.	Implant Sticker/ Invoice	{DOC_IMPLANT_STICKI}	{DOC_IMPLANT_STICKI}	Photocopy
9.	EFT (Copy of cancelled cheque/Copy of passbook or bank statement with Payee/account holders name and IFSC code)	{DOC_EFT_YES}	{DOC_EFT_NO}	Photocopy
10.	Consultation Paper	{DOC_CONSULTATION}	{DOC_CONSULTATION}	Photocopy
11.	Age Proof	{DOC_AGE_PROOF_YE}	{DOC_AGE_PROOF_NC}	Photocopy
12.	Indoor Case Paper	{DOC_INDOOR_CASE_F}	{DOC_INDOOR_CASE_F}	Photocopy
13.	Doctor Prescriptions	{DOC_DOCTOR_PRESC}	{DOC_DOCTOR_PRESC}	Original
14.	Part D - C-KYC Form (Only for Retail/ Individual customers if claiming >` 1 lakh)	{DOC_PART_D_C_KYC}	{DOC_PART_D_C_KYC}	Original
15.	PAN Card Copy of the Proposer/ Employee (Mandatory)	{DOC_PAN_CARD_YES}		Photocopy

^Kindly **do not** furnish **Aadhaar card** and send any other document for ID proof.



**ICICI Lombard General Insurance Company limited**

**Mailing Address:** ICICI Lombard Healthcare, ICICI Bank Tower, Plot No. 12, Financial District, Nanakram Guda, Gachibowli, Hyderabad, Telangana-500032

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

**Visit us at:** [www.icicilombard.com](http://www.icicilombard.com) • **E-Mail us at:** [ihealthcare@icicilombard.com](mailto:ihealthcare@icicilombard.com) • **Toll Free Number:** 1800 2666. • **Toll Free Fax Number:** 1800 209 8880  
IRDA Registration No. 115



## ICICI Lombard Health Care Claim Form - Hospitalization



(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
- ★ You can track your claim status at: [www.icicilombard.com](http://www.icicilombard.com) → Claims → Health Claims → Services → Track your claims

### Part - A (To be filled by Insured)

TO BE FILLED IN CAPITAL LETTERS ONLY

**A1. Type of Claim :**

- ☒ Main Hospitalisation Expenses  
☐ Pre & Post Hospitalisation Expenses

Cashless Obtained : ☐ Yes ☐ No

**A2. Details of the Insured person in respect of whom claim is made: (patient details)**

Name of the Patient:	MRITWIKA BHATTACHARYA		
Card No./ UHID of the Patient:	191091338		
Gender :	Date of Birth :		
<input type="checkbox"/> Male <input checked="" type="checkbox"/> Female			
<input type="checkbox"/> Transgender	DD/MM/Y		
Occupation :	<input type="checkbox"/> Service <input type="checkbox"/> Self Employed <input type="checkbox"/> Homemaker <input type="checkbox"/> Student		
	<input type="checkbox"/> Retired <input type="checkbox"/> Other		
	<input type="checkbox"/> (Please specify) _____		
Are you previously covered by any other Mediclaim/ Health Insurance:	<input type="checkbox"/> Yes <input type="checkbox"/> No		
	<input type="checkbox"/> If yes, Company name: _____		
Current residential address :	_____		
City :	BANGALORE	State : KARNATAKA	400-101
	Pin code :		
Mobile No :	9899647831	Landline No :	
E-mail :	GHOSH.ANIRBAN2@GMAIL.COM		

ABHA Number : \_\_\_\_\_

ABHA is a 14 digit number that will uniquely identify you as a participant in India's digital healthcare ecosystem.

<b>A3. For Group/ Corporate Policy</b>	<b>For Individual/ Retail Policy</b> (*Mandatory)
Member ID No./ Employee ID (Client ID): _____	*Claim Intimation Service Request no.: _____
Group/ Company name: _____	Is this a renewal policy: <input type="checkbox"/> Yes <input type="checkbox"/> No
	If Yes, kindly mention your previous policy no.: _____
<b>A4. Name of the Proposer*/Employee:</b>	MRITWIKA BHATTACHARYA
Relationship with Proposer*: _____	(*Policy Holder. For Retail policy, Proposer name required. For Corporate policy, provide Employee name)
Current Policy No.: 4225I/ELVT/356173853/00/000	191091338
Card No./ UHID: _____	_____
<b>A5. Diagnosis as per discharge summary:</b>	National Institute of Mental Health and Neuro Science
Name of hospital where admitted:	<input type="checkbox"/> Day care <input type="checkbox"/> Single occupancy <input type="checkbox"/> Twin sharing
Room category occupied :	<input type="checkbox"/> 3 or more beds per room
	<input type="checkbox"/> Others _____
Date of Admission: 24-Oct-2024 Time: HH/MM	Date of Discharge: 25-Nov-2024 Time: HH/MM
Date of injury sustained or disease/ Illness first detected:	DD/MM/YYYY
If Injury, give cause:	<input type="checkbox"/> Self inflicted <input type="checkbox"/> Road traffic accident
	<input type="checkbox"/> Substance abuse/ Alcohol consumption
	<input type="checkbox"/> Others _____
If Medico legal :	<input type="checkbox"/> Yes <input type="checkbox"/> No Reported to police : <input type="checkbox"/> Yes <input type="checkbox"/> No
	MLC Report & Police FIR attached: <input type="checkbox"/> Yes <input type="checkbox"/> No
	(If yes, attach report)
System of Medicine:	<input type="checkbox"/> Allopathy <input type="checkbox"/> AYUSH

Is there any another claim in any of our policies towards ☐ Yes ☐ No If yes, provide AL/Claim No. \_\_\_\_\_  
the above incident?

**A6.Are you covered under any Topup/Additional policy ::** ☐ Yes ☐ No If yes, provide AL/Claim No. \_\_\_\_\_

**A7. Currently covered by any other Mediclaim/ Health Insurance ::** ☐ Yes ☐ No

Date of commencement of first Insurance without break: DD/MM/YYYY

Have you been hospitalized in the last 4 years since inception of contract: ☐ Yes ☐ No Date : DD/MM/YYYY

Dignosis : \_\_\_\_\_

Have you lodged any claim against this particular admission date/ attached bills with any other Insurance company: If yes, attach settlement letter,

Company name: \_\_\_\_\_

Sum Insured : ₹ \_\_\_\_\_

Policy No: \_\_\_\_\_

### A8. Details of Claim

#### a) Details of the treatment expenses claimed

i. Pre-hospitalization expenses: ₹ _____	ii. Hospitalization expenses: ₹ _____
iii. Post-hospitalization expenses: ₹ _____	iv. Health-check up cost: ₹ _____
v. Ambulance charges: ₹ _____	vi. Others: ₹ _____
vii. Pre-hospitalization period: _____ Days	Total: ₹ _____
	viii. Post-hospitalization period: _____ Days

#### b) Claim for

i. Domiciliary Hospitalization: <input type="checkbox"/> Yes <input type="checkbox"/> No	iii. Extended care/ Inpatient rehabilitation: <input type="checkbox"/> Yes <input type="checkbox"/> No
ii. Day care: <input type="checkbox"/> Yes <input type="checkbox"/> No	

#### c) Details of lump sum/ cash benefit claimed:

i. Hospital daily cash: ₹ _____	ii. Maternity: ₹ _____
iii. Critical illness/PA/Donor Expenses: ₹ _____	iv. Convalescence: ₹ _____
v. Pre/ Post hospitalization lump sum benefit: ₹ _____	vi. Others: ₹ _____

### A9. Details of the amount claimed

Bill heads (as applicable)	Bill number	Bill date	Bills attached	Amount
Room rent		<u>DD/ MM/</u>	<input type="checkbox"/> Yes <input type="checkbox"/> No	₹ _____
Doctors consultation/ Visit charges		<u>DD/ MM/</u>	<input type="checkbox"/> Yes <input type="checkbox"/> No	₹ _____
Investigation charges (Includes Radiology and Pathology reports)		<u>DD/ MM/</u>	<input type="checkbox"/> Yes <input type="checkbox"/> No	₹ _____
Surgeon and Asst. surgeon charges		<u>DD/ MM/</u>	<input type="checkbox"/> Yes <input type="checkbox"/> No	₹ _____
Anesthetist charges & Operation theatre charges		<u>DD/ MM/</u>	<input type="checkbox"/> Yes <input type="checkbox"/> No	₹ _____
Equipment charges/ Procedure charges		<u>DD/ MM/</u>	<input type="checkbox"/> Yes <input type="checkbox"/> No	₹ _____
Cost of implant (If any)		<u>DD/ MM/</u>	<input type="checkbox"/> Yes <input type="checkbox"/> No	₹ _____

Medicine charges & Pharmacy charges		DD/ MM/ )	<input type="checkbox"/> Yes <input type="checkbox"/> No	₹
Taxes/Surcharges/Service		DD/ MM/ )	<input type="checkbox"/> Yes <input type="checkbox"/> No	₹
Discount provided by Hospital/Miscellaneous charges		DD/ MM/ )	<input type="checkbox"/> Yes <input type="checkbox"/> No	₹
Other TPA/Insurance settled amount		DD/ MM/ )	<input type="checkbox"/> Yes <input type="checkbox"/> No	₹
Pre hospitalization bills & Post hospitalization bills (If any)		DD/ MM/ )	<input type="checkbox"/> Yes <input type="checkbox"/> No	₹
Total claimed amount (In ₹)(Total claimed amount should be equal to the amount in attached bill documents)				₹ 233860.00

**MANDATORY: ALL CLAIM SETTLEMENTS SHOULD BE MADE THROUGH NEFT(AS PER REGULATORY NORMS) PLEASE PROVIDE YOUR BANK ACCOUNT DETAILS ALONG WITH COPY OF CANCELLED CHEQUE/COPY OF PASSBOOK OR BANK STATEMENT WITH PAYEE/ACCOUNT HOLDERS NAME AND IFSC CODE.)**

**A10.** In support of the above claim, I enclose following documents in original (Please indicate by ticking in the **Yes/ No** column below)

Type of Document(s) - *Mandatory	Yes	No	Type of Document(s) - As Applicable	Yes	No
1.Claim form duly filled and signed*	<input type="checkbox"/>	<input type="checkbox"/>	9. ICICI Lombard GIC Authorisation Letter	<input type="checkbox"/>	<input type="checkbox"/>
2.Cancelled cheque (for bank account details)*	<input type="checkbox"/>	<input type="checkbox"/>	10. Implant name and invoice (if any) with implant sticker	<input type="checkbox"/>	<input type="checkbox"/>
3.Discharge summary*	<input type="checkbox"/>	<input type="checkbox"/>	11. Indoor Case Papers	<input type="checkbox"/>	<input type="checkbox"/>
4. Hospital bills, Final/ Main hospital bill and other bills (if any)*	<input type="checkbox"/>	<input type="checkbox"/>	12. Prescription papers/ Consultation papers	<input type="checkbox"/>	<input type="checkbox"/>
5. Hospital payment receipt & other receipts supporting bills*	<input type="checkbox"/>	<input type="checkbox"/>	13. C-KYC FORM (Only for Retail/Individual customers, claiming > ` 1Lakh)	<input type="checkbox"/>	<input type="checkbox"/>
6. Investigation reports* (Including ECG/ CT/ MRI/ USG/ HPE)	<input type="checkbox"/>	<input type="checkbox"/>	14. Others (details)	<input type="checkbox"/>	<input type="checkbox"/>
7. Medicine/ Pharmacy bills with doctors prescription*	<input type="checkbox"/>	<input type="checkbox"/>			
8. Age proof (Driving License/ PAN card/ Passport)^*	<input type="checkbox"/>	<input type="checkbox"/>			

**Please attach all the documents as per above serial number** Films like x-ray film, CT Scan film, MRI Scan film, etc. are not required. Provide reports only

**A11.Please provide the reason for delay in submitting the documents**  
(Post 30 days from Date of Discharge)

Provide Details (If Applicable)

**Declaration by the Insured:**

I hereby declare that the information furnished in this claim form is true and correct to the best of my knowledge and belief. If I have made any false or untrue statement, suppression or concealment of any material fact with respect to questions asked in relation to this claim, my right to claim reimbursement shall be forfeited. I also consent and authorize TPA/ insurance company, to seek necessary medical information/ documents from any hospital/ Medical Practitioner who has attended on the person against whom this claim is made. I hereby declare that I have included all the bills/ receipts for the purpose of this claim and that I will not be making any supplementary claim except the pre/ post-hospitalization claim, if any I hereby give my consent to the Company to verify my identity through Central KYC Registry or UIDAI or through any other modes for the purpose of undertaking KYC.

Date: 31-Dec-2024

Place:

Insured's Signature:

^ Kindly **do not** furnish **Aadhaar card** and send any other document for ID proof.

**Part - B (To be filled by Treating Doctor/ Hospital only)**

**B1. Details of the Hospital/ Nursing home in which treatment was taken**

Name of the Hospital/ Nursing home:

National Institute of Mental Health and Neuro Science

Address:

City: 

BANGALORE

KARNATAKA

State:

Pincode: Telephone no.: Mobile no.:

ROHINI ID\*:

If Non Network, provide below details

Type of Hospital:: ☐ Network ☐ Non Network

Registration No. with State Code: PAN:

Number of Inpatient beds:

Facilities available in the hospital: ☐ OT: ☐ ICU:

**B2. Details of the attending Medical Practitioner/ Doctor/ Treating Physician or Surgeon**

Name:

Qualification:

Registration no:

Telephone no.: Mobile no.:

**B3. Details of the patient admitted**

Name of the patient: 

MRITWIKHA BHATTACHARYA

IP Registration no.:

☐ Male ☒ Female ☐ Transgender

Gender :

Date of Birth : 

DD/MM/YYYY

Type of Admission : 

☐ Emergency ☐ Planned ☐ Day Care  
☐ Maternity  
☐ Surgical Procedure  
☐ Multiple Surgical Procedure  
☐ Medical Treatment  
☐ G ☐ P ☐ A ☐ L  
☐ Yes ☐ No  
☐ Discharge to home  
☐ Discharge to another hospital ☐ Deceased

Type of Treatment:

If Maternity, Date of Delivery: 

DD/ MM/ YYYY

Gravida Status :

Premature Baby :

Status at time of discharge:

Total claimed amount: ₹ 

233860.00

**B4. Details of the procedure**

Pre-authorization obtained : 

☐ Yes ☐ No If yes, Pre-authorization No.:

If authorization by network hospital not obtained, give reason :

Date of injury sustained or disease/ illness first detected: 

DD/ MM/ YYYY

If Injury, give cause: 

☐ Self inflicted ☐ Road traffic accident  
☐ Substance abuse/Alcohol consumption  
Others

If Medico legal: ☐ Yes ☐ Yes

Reported to police: ☐ Yes ☐ Yes

MLC Report & Police FIR attached: ☐ Yes ☐ Yes

(If yes, attach report)  
FIR no. \_\_\_\_\_

If not reported to Police, give reason:

FIR no. \_\_\_\_\_

If not  
reported  
to  
Police,  
give  
reason: \_\_\_\_\_

If injury due to substance abuse/alcohol consumption,  
test conducted to establish this:

☐ Yes ☐ No (If yes, attach report)

**B5. This section is mandatory only if your health policy is not provided by your employer**

<b>A) Diagnosis (ICD 10 Code primary &amp; additional diagnosis)</b>	
i) Primary diagnosis (with ICD 10 code )	
ii) Additional diagnosis (with ICD 10 code)	
ciii) Procedure diagnosis (with ICD 10 PCS code)	
<b>B) Nature of surgery/ treatment given for present ailment</b>	
<b>C) Date of first consultation (Prior to hospitalization)</b>	
<b>D) Presenting complaints of the patient during admission</b>	
<b>E) Past medical history of the patient along with duration of illness</b> (If yes, attach first & all past consultation paper)	
<b>F) Was the patient under influence of alcohol during admission</b>	
<b>G) Whether the present treatment ailment is a complication of pre-existing disease ?</b>	
i) If yes, please specify the disease (or) complication of any previous surgery done ?	
ii) If yes, please specify the details	
<b>H) Whether the disease/ disorder is congenital in nature ?</b>	
<b>I) Number of in-patient beds in the hospital (including ICU)</b>	

**Declaration by the hospital:**

**We hereby declare that the information furnished in this Claim Form is true & correct to the best of our knowledge and belief. If we have made any false or untrue statement, suppression or concealment of any material fact, our right to claim under this claim shall be forfeited.**

Registration No. of Hospital Date: 31-Dec-2024 Doctor's Seal and Signature \_\_\_\_\_  
(Rubber stamp of the hospital)

As per the policy Terms and Conditions, the Company reserves its right to have the Insured examined by a doctor appointed by it for verification of diagnosis.

**Part - C - NEFT Form**  
(For Direct Electronic Fund Transfer)

**MANDATORY: ALL CLAIM SETTLEMENTS SHOULD BE MADE THROUGH NEFT(AS PER REGULATORY NORMS)  
PLEASE PROVIDE YOUR BANK ACCOUNT DETAILS ALONG WITH COPY OF CANCELLED CHEQUE / BANK  
PASSBOOK / BANK STATEMENT.)**

**C1.Patient's Name:** MRITWIKHA BHATTACHARYA

(in respect of whom claim is made):

**C2.Policy Number:** 4225I/ELVT/356173853/00/000

**C3.Card No./ UHID No:** 191091338



**C4.Group/Company Name** (for Group/Corporate policy holders):

**C5.Claim Number** (if allotted):

MRN31122024000175457

**C6.Claim Number** (if allotted):

MRN31122024

**C5.EMAIL:**

GHOSH.ANIRBAN2@GMAIL.COM

**C8. 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 as stated in mandatory\*)
- ☐ Cancelled cheque copy ☐ Bank attested copy of Passbook with IFSC code

**C9. Please provide the below details (all fields are compulsory)**

- Proposer/ policy holder name\*(as per bank records): MRITWIKHA BHATTACHARYA
- Proposer/ policy holder Bank account no.: 398501500357
- Name of the bank: ICICI Bank
- Branch name: SECTOR NOIDA
- Address of the bank:
- IFSC code no. of the bank: ICIC0003985 (should be same as per the provided cheque leaflet)
- PAN No. of the Proposer: AUAPG8891R

**\*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**

☒ I understand and agree that a verification may be carried out for this claim

**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](http://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.

Anirban Ghosh



**ICICI Lombard General Insurance Company limited**

**Mailing Address:** ICICI Lombard Healthcare, ICICI Bank Tower, Plot No. 12, Financial District, Nanakram Guda, Gachibowli, Hyderabad, Telangana-500032  
**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

**Part D - 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)

Name*	<input type="text"/>
(Same as ID proof)	
Name*	<input type="text"/>
(Same as ID proof)	
Maiden Name (If any*)	<input type="text"/>
Father / Spouse Name*	<input type="text"/>
Mother Name*	<input type="text"/>
Date of Birth*	<input type="text" value="DD/ MM/ YYYY"/>
Gender* :	<input type="checkbox"/> M- Male <input type="checkbox"/> F- Female <input type="checkbox"/> T-Transgender
Marital Status* :	<input type="checkbox"/> Married <input type="checkbox"/> Unmarried <input type="checkbox"/> Others
Citizenship* :	<input type="checkbox"/> IN- Indian <input type="checkbox"/> Others (ISO 3166 Country Code)
Residential Status* :	<input type="checkbox"/> Resident Individual <input type="checkbox"/> Non Resident Indian <input type="checkbox"/> Foreign National <input type="checkbox"/> Person of Indian Origin
Occupation Type* :	<input type="checkbox"/> S-Service ( <input type="checkbox"/> Private Sector <input type="checkbox"/> Public Sector <input type="checkbox"/> Government Sector ) <input type="checkbox"/> O-Others ( <input type="checkbox"/> Professional <input type="checkbox"/> Self Employed <input type="checkbox"/> Retired <input type="checkbox"/> Housewife <input type="checkbox"/> Student )

☐ B-Business ☐ X- Not Categorised

☐ **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 DD/ MM/ YYYY \_\_\_\_\_

☐ B- Voter ID Card \_\_\_\_\_

☐ C- PAN Card \_\_\_\_\_

☐ D- Driving Licence \_\_\_\_\_ Driving Licence Expiry Date DD/ MM/ YYYY \_\_\_\_\_

☐ 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^\*)  
☐ Voter Identity Card ☐ NREGA Job Card ☐ Others  
☐ Simplified Measures Account - Document Type code

**Address**

Line 1\* \_\_\_\_\_

Line 2 \_\_\_\_\_

Line 3 \_\_\_\_\_ City / Town / Village\* \_\_\_\_\_

District\* \_\_\_\_\_ Pin / Post Code\* \_\_\_\_\_ State / U.T Code\* \_\_\_\_\_

ISO 3166 Country Code\* \_\_\_\_\_

^Kindly **do not** furnish **Aadhaar card** and send any other document for ID proof.

☐ **4.2 CORRESPONDENCE / LOCAL ADDRESS DETAILS \*** (Please see instruction E at the end)

☐ Same as Current / Permanent / Overseas Address details (In case of multiple correspondence / local addresses, please fill '**Annexure A1**') \_\_\_\_\_

Line 1\* \_\_\_\_\_

Line 2 \_\_\_\_\_

Line 3 \_\_\_\_\_ City / Town / Village\* \_\_\_\_\_

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

☐ **4.3 ADDRESS IN THE JURISDICTION DETAILS WHERE APPLICANT IS RESIDENT OUTSIDE INDIA FOR TAX PURPOSES\*** (Applicable if section 2 is ticked)

☐ Same as Current / Permanent / Overseas Address details ☐ Same as Correspondence / Local Address details

Line 1\* \_\_\_\_\_

Line 2 \_\_\_\_\_

Line \_\_\_\_\_ City / Town / Village\* \_\_\_\_\_

3 \_\_\_\_\_  
State\* \_\_\_\_\_ Zip / Post Code\* \_\_\_\_\_

ISO 3166 Country Code\* \_\_\_\_\_

☐ **5. CONTACT DETAILS** (All communications will be sent on provided)

Tel. (Off) \_\_\_\_\_ Tel. (Res) \_\_\_\_\_ Mobile \_\_\_\_\_

FAX \_\_\_\_\_ Email ID \_\_\_\_\_

**6. DETAILS OF RELATED PERSON** (In case of additional related persons, please fill 'Annexure B1' ) (please refer instruction G at the end)

☐ **Addition of Related Person** ☐ **Deletion of Related Person**

☐ **KYC Number of Related Person (if available\*)**

Related Person Type\* :

☐ Guardian of Minor ☐ Assignee  
☐ Authorized Representative

Name\* \_\_\_\_\_

(if KYC number and name are provided below details of section 6 are optional)

**PROOF OF IDENTITY [PoI] OF RELATED PERSON\*** (Please see instruction (H) at the end)

☐ **A- Passport Number** \_\_\_\_\_ **Passport Expiry Date** DD/ MM/ YYYY \_\_\_\_\_

☐ **B- Voter ID Card** \_\_\_\_\_

☐ **C- PAN Card** \_\_\_\_\_

☐ **D- Driving Licence** \_\_\_\_\_ **Driving Licence Expiry Date** DD/ MM/ YYYY \_\_\_\_\_

☐ **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  
\_\_\_\_\_

☐ **7. REMARKS (If any)** Mobile no. / Email-ID (Please refer instruction F at the end)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

☐ **8. APPLICANT DECLARATION**

- I hereby declare that the details furnished above are true and correct to the best of my knowledge and belief and I undertake to inform you of any changes therein, immediately. In case any of the above information is found to be false or untrue or misleading or misrepresenting, I am aware that I may be held liable for it.
- I hereby consent to receiving information from Central KYC Registry through SMS/Email on the above registered number/email address.

[Signature / Thumb Impression]

Signature / Thumb Impression of Applicant

Date 31-Dec-2024 \_\_\_\_\_ Place : \_\_\_\_\_

: \_\_\_\_\_

☐ 9. ATTESTATION / FOR OFFICE USE ONLY

Documents Received ☐ Certified Copies

KYC VERIFICATION CARRIED OUT BY

Date

Emp. Name

Emp. Code

Emp. Designation

Emp. Branch

[Employee Signature]

KYC VERIFICATION CARRIED OUT BY

Name

Code

[Employee Signature]

^Kindly **do not** furnish **Aadhaar card** and send any other document for ID proof.

CENTRAL KYC REGISTRY | Instructions / Checklist / Guidelines for filling Individual KYC Application Form

General Instructions:

1. Fields marked with "\*" are mandatory fields.
2. Tick '✓' wherever applicable.
3. Self-Certification of documents is mandatory.
4. Please fill the form in English and in BLOCK Letters.
5. Please fill all dates in DD-MM-YYYY format.
6. Wherever state code and country code is to be furnished, the same should be the two-digit code as per Indian Motor Vehicle, 1988 and ISO 3166 country code respectively list of which is available at the end.
7. KYC number of applicant is mandatory for updation of KYC details.
8. For particular section update, please tick (ü) in the box available before the section number and strike off the sections not required to be updated.
9. In case of 'Small Account type' only personal details at section number 1 and 2, photograph, signature and self-certification required.

**A Clarification / Guidelines on filling 'Personal Details' section**

1. Name: Please state the name with Prefix (Mr/Mrs/Ms/Dr/etc.). The name should match the name as mentioned in the Proof of Identity submitted failing which the application is liable to be rejected.
2. Either father's name or spouse's name is to be mandatorily furnished. In case PAN is not available father's name is mandatory.

**B Clarification / Guidelines on filling details if applicant residence for tax purposes in jurisdiction(s) outside India**

1. Tax identification Number (TIN): TIN need not be reported if it has not been issued by the jurisdiction. However, if the said jurisdiction has issued a high integrity number with an equivalent level of identification (a "Functional equivalent"), the same may be reported. Examples of that type of number for individual include, a social security/insurance number, citizen/personal identification/services code/number, and resident registration number)

**C Clarification / Guidelines on filling 'Proof of Identity [Pol]' section**

1. If driving license number or passport is provided as proof of identity then expiry date is to be mandatorily furnished.
2. Mention identification / reference number if 'Z- Others (any document notified by the central government)' is ticked.
3. In case of Simplified Measures Accounts for verifying the identity of the applicant, any one of the following documents can also be submitted and undernoted relevant code may be mentioned in point 3 (S).

Document Code	Description
01	Identity card with applicant's photograph issued by Central/ State Government Departments, Statutory/ Regulatory Authorities, Public Sector Undertakings, Scheduled Commercial Banks, and Public Financial Institutions.
02	Letter issued by a gazetted officer, with a duly attested photograph of the person.

**D Clarification / Guidelines on filling 'Proof of Address [PoA] - Current / Permanent / Overseas Address details' section**

1. PoA to be submitted only if the submitted Pol does not have an address or address as per Pol is invalid or not in force.
2. State / U.T Code and Pin / Post Code will not be mandatory for Overseas addresses.
3. In case of Simplified Measures Accounts for verifying the address of the applicant, any one of the following documents can also be submitted and undernoted relevant code may be mentioned in point 4.1.

Document Code	Description
---------------	-------------

01	Utility bill which is not more than two months old of any service provider (electricity, telephone, post-paid mobile phone, piped gas, water bill).
02	Property or Municipal Tax receipt.
03	Bank account or Post Office savings bank account statement.
04	Pension or family pension payment orders (PPOs) issued to retired employees by Government Departments or Public Sector Undertakings, if they contain the address.
05	Letter of allotment of accommodation from employer issued by State or Central Government departments, statutory or regulatory bodies, public sector undertakings, scheduled commercial banks, financial institutions and listed companies. Similarly, leave and license agreements with such employers allotting official accommodation.
06	Documents issued by Government departments of foreign jurisdictions and letter issued by Foreign Embassy or Mission in India.

**E Clarification / Guidelines on filling ‘Proof of Address [PoA] - Correspondence / Local Address details’ section**

1. To be filled only in case the PoA is not the local address or address where the customer is currently residing. No separate PoA is required to be submitted.
2. In case of multiple correspondence / local addresses, Please fill ‘Annexure A1’

**F Clarification / Guidelines on filling ‘Contact details’ section**

1. Please mention two- digit country code and 10 digit mobile number (e.g. for Indian mobile number mention 91-9999999999).
2. Do not add ‘0’ in the beginning of Mobile number.

**G Clarification / Guidelines on filling ‘Related Person details’ section**

1. Provide KYC number of related person if available.

**H Clarification / Guidelines on filling ‘Related Person details – Proof of Identity [PoI] of Related Person’ section**

1. Mention identification / reference number if ‘Z- Others (any document notified by the central government)’ is ticked.

**List of two – digit state / U.T codes as per Indian Motor Vehicle Act, 1988**

State / U.T	Code	State / U.T	Code	State / U.T	Code
Andaman & Nicobar	AN	Himachal Pradesh	HP	Pondicherry	PY
Andhra Pradesh	AP	Jammu & Kashmir	JK	Punjab	PB
Arunachal Pradesh	AR	Jharkhand	JH	Rajasthan	RJ
Assam	AS	Karnataka	KA	Sikkim	SK
Bihar	BR	Kerala	KL	Tamil Nadu	TN
Chandigarh	CH	Lakshadweep	LD	Telangana	TS
Chattisgarh	CG	Madhya Pradesh	MP	Tripura	TR
Dadra and Nagar Haveli	DN	Maharashtra	MH	Uttar Pradesh	UP
Daman & Diu	DD	Manipur	MN	Daman & Diu	DD
Delhi	DL	Meghalaya	ML	Uttarakhand	UA
Goa	GA	Mizoram	MZ	West Bengal	WB
Gujarat	GJ	Nagaland	NL	Other	XX
Haryana	HR	Orissa	OR		

**List of ISO 3166 two- digit Country Code**

Country	Country Code	Country	Country Code	Country	Country Code	Country	Country Code
Afghanistan	AF	Dominican Republic	DO	Libya	LY	Saint Pierre and Miquelon	FM
Aland Islands	AX	Ecuador	EC	Liechtenstein	LI	Saint Vincent and the Grenadines	VC
Albania	AL	Egypt	EG	Lithuania	LT	Samoa	WS
Algeria	DZ	El Salvador	SV	Luxembourg	LU	San Marino	SM
American Samoa	AS	Equatorial Guinea	GQ	Macao	MO	Sao Tome and Principe	ST
Andorra	AD	Eritrea	ER	Macedonia, the former Yugoslav Republic of	MK	Saudi Arabia	SA
Angola	AO	Estonia	EE	Madagascar	MG	Senegal	SN
Anguilla	AI	Ethiopia	ET	Malawi	MW	Serbia	RS
Antarctica	AQ	Falkland Islands (Malvinas)	FK	Malaysia	MY	Seychelles	SC
Antigua and Barbuda	AG	Faroe Islands	FO	Maldives	MV	Sierra Leone	SL

[illegible]

### Important Instructions:

**For office use only** Application Type\* ☐ New ☐ Update

## 1. CORRESPONDENCE / LOCAL ADDRESS DETAILS (Please see instruction E at the end)

Line 1\*

Line 2

Line 3

City / Town / Village\*

State\*

Zip / Post Code\*

ISO 3166 Country Code\*

Tel. (Off) \_\_\_\_\_ Tel. (Res) \_\_\_\_\_ Mobile \_\_\_\_\_  
FAX \_\_\_\_\_ Email ID \_\_\_\_\_

- I hereby declare that the details furnished above are true and correct to the best of my knowledge and belief and I undertake to inform you of any changes therein, immediately. In case any of the above information is found to be false or untrue or misleading or misrepresenting, I am aware that I may be held liable for it.

## Annexure B1

### Important Instructions:

B) Please fill the form in English and in BLOCK letters.

D) Please read section wise detailed guidelines / instructions at the end.

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.

G) KYC number of applicant is mandatory for update application.

**For office use only** Application Type\* ☐ New ☐ Update

(To be filled by financial institution) KYC Number

(Mandatory for KYC update request)

### 1. DETAILS OF RELATED PERSON (Please refer instruction G at the end)

☐ Addition of Related Person ☐ Deletion of Related Person

☐ **KYC Number of Related Person (if available\*)**

Related Person Type\* :

☐ Guardian of Minor ☐ Assignee☐ Authorized Representative

Name\*

(if KYC number and name are provided below details of section 6 are optional)

PROOF OF IDENTITY [PoI] OF RELATED PERSON\* (Please see instruction (H) at the end)

A- Passport Number  Passport Expiry Date DD/ MM/ YYYY

☐ B- Voter ID Card

☐ C- PAN Card

☐ D- Driving Licence  Driving Licence Expiry Date DD/ MM/ YYYY

☐ 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

## 2. APPLICANT DECLARATION

- I hereby declare that the details furnished above are true and correct to the best of my knowledge and belief and I undertake to inform you of any changes therein, immediately. In case any of the above information is found to be false or untrue or misleading or misrepresenting, I am aware that I may be held liable for it.

Date 31-Dec-2024 | Place :

\_\_\_\_\_

\_\_\_\_\_

Signature / Thumb Impression of Applicant

#### 4. ATTESTATION / FOR OFFICE USE ONLY

Documents Received ☐ Certified Copies

KYC VERIFICATION CARRIED OUT BY

Date 31-Dec-2024

Emp. Name

Emp. Code 

Emp. Designation

Emp. Branch

KYC VERIFICATION CARRIED OUT BY

Name

Code

[Employee Signature]

[Employee Signature]



^Kindly **do not** furnish **Aadhaar card** and send any other document for ID proof.



**ICICI Lombard General Insurance Company limited**

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Nanakram Guda, Gachibowli, Hyderabad, Telangana-500032

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

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• **Toll Free Fax Number:** 1800 209 8880  
IRDA Registration No. 115

