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 Patient: ANITA KUMARI

Card No./UHID of the Patient: IL22265190603

Gender: Male ☐ Female ☑ Date of Birth: 10/03/1971 Completed age: Years: 53 Months:

Occupation: Service ☐ Self Employed ☐ Homemaker ☑ Student ☐ Retired ☐ Other ☐

(Please specify:)

Are you previously covered by any other Mediclaim/ Health Insurance: Yes ☐ No ☑ If yes, Company name:

Current residential address: B-38 Mitramandal colony, saket vihar ,anishabad, patna-800002, Bihar

City: Patna Pin code: 800002

State: Bihar Landline no. 8789091992

Mobile no. 87890919

E-mail: abhisheksingh4312@gmail.co

A3. For **Group/ Corporate** Policy

Member ID No./Employee ID (Client ID): 3053684

Group/ Company name: Boeing India P

For **Individual/ Retail** Policy (*Mandatory)

*Claim Intimation Service Request no.:

Is this a renewal policy: Yes ☐ No ☐

If Yes, kindly mention your previous policy no.:

A4. Name of the Proposer*: ANITA KUMARI

Relationship with the Proposer*: SON

Current Policy No.: 4016/X/198469072/04/0(Card No./ UHID: IL22265190603

(* Policy Holder. For Retail Policy, Proposer name required. For Corporate policy, provide Employee name)

A5. Nature of disease/ illness contracted or injury suffered for which Insured was hospitalized (Diagnosis):

Hypercalcemia and Pedal edema, knee pain

Name of hospital where admitted: RUBAN MEMORIAL HOSPITAL PATNA

Room category occupied: Day care ☑ Single occupancy ☐ Twin sharing ☑ 3 or more beds per room ☐

Others

Date of Admission: 15/07/2024 Time: DD/MM/YYY Date of Discharge: 24/07/2024

Time: 11:23 AM

Date of injury sustained or disease/ Illness first detected: 15/06/2024

If Injury, give cause: Self inflicted ☐ Road traffic accident ☐ Substance abuse/ Alcohol consumption ☑ Others:

If Medico legal: Yes ☐ No ☐ Reported to police: Yes ☐ No ☐

MLC Report & Police FIR attached: Yes ☐ No ☐ (If yes, attach report)

System of Medicine:

A6. Are you covered under any Topup/Additional policy : Yes ☑ No ☐ If yes, provide policy no.

4016/X/221407019/03/000

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: 22/03/20

Dignosis: laparoscopic surgery

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

Company name: Policy No. Sum Insured:

A8. Details of Claim

a) Details of the treatment expenses claimed

i. Pre-hospitalization expenses:	14527	ii. Hospitalization expenses:	
iii. Post-hospitalization expenses:	17552	iv. Health-check up cost:	
v. Ambulance charges:		vi. Others	
		Total:	
vii. Pre-hospitalization period	30 Days	viii. Post-hospitalization period:	60 Days

b) Claim for

i. Domiciliary Hospitalization: Yes ☐ No ☐ (If yes, provide details in annexure)

ii. Day care: Yes ☐ No ☐

iii. Extended care/ Inpatient rehabilitation: Yes ☐ No ☐

i. Hospital daily cash:		ii. Surgical cash:	
iii. Critical illness:		iv. Convalescence:	
v. Pre/ Post hospitalizationlump sum benefit:	32079	vi. Others:	

c) Details of lump sum/ cash benefit claimed:

A9. Details of the amount claimed

Bill heads (as applicable)	Bill number	Bill date	Bills attached	Amount
Room rent:		DD/MM/YYYY	Yes ☐ No ☐	
Doctors consultation/ Visit charges:		DD/MM/YYYY	Yes ☐ No ☐	
Investigation charges (Includes Radiology and Pathology reports):		DD/MM/YYYY	Yes ☐ No ☐	
Surgeon and Asst. surgeon charges:		DD/MM/YYYY	Yes ☐ No ☐	
Anesthetist charges & Operation theatre charges:		DD/MM/YYYY	Yes ☐ No ☐	
Equipment charges/ Procedure charges:		DD/MM/YYYY	Yes ☐ No ☐	
Cost of implant (If any):		DD/MM/YYYY	Yes ☐ No ☐	
Medicine charges (Includes ward and OT medicines and consumables):		DD/MM/YYYY	Yes ☐ No ☐	
Pharmacy charges:		DD/MM/YYYY	Yes ☐ No ☐	
Taxes/ Surcharges/ Service charge:		DD/MM/YYYY	Yes ☐ No ☐	
Miscellaneous/ Other charges:		DD/MM/YYYY	Yes ☐ No ☐	
Pre hospitalization bills (If any):		DD/MM/YYYY	Yes ☐ No ☐	
Post hospitalization bills (If any):		DD/MM/YYYY	Yes ☐ No ☐	
Discount provided by hospital (If any):		DD/MM/YYYY	Yes ☐ No ☐	

Total claimed amount (In INR) (Total claimed amount should be equal to the amount in attached bill documents)

Type of Document(s) - *Mandatory	Yes	No	Type of Document(s) - As Applicable	Yes	No
1. Claim form duly filled and signed*	☑	☐	9. ICICI Lombard GIC Authorisation Letter	☐	☐
2. Discharge summary*	☑	☐	10. Implant name and invoice (if any) with implant sticker	☐	☐
3. Hospital bills, Final/ main hospital bill and other bills (if any)*	☑	☐	11. Indoor Case Papers	☐	☐
4. Hospital payment receipt & other receipts supporting bills*	☑	☐	12. Prescription papers/ Consultation papers	☐	☐
5. Investigation reports* (Including ECG/ CT/ MRI/ USG/ HPE)	☑	☐	13. Others (details)	☐	☐
6. Medicine/ Pharmacy bills with doctors prescription**	☑	☐			

7. Age proof (Driving License/ PAN card/ Passport/ Aadhar copy)*	☑ ☐		
8. Part - C (For EFT/RTGS/ NEFT)*	☐	14. Part - D (KYC documents required if total claimed amt. is > 1 lakh)	☐ ☐

***Mandatory.**

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

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.

Date: 29/07/2024

Place: PATNA

Insured's Signature:_____

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

Name of the Hospital/ Nursing home:

Address:

City: State:

Pincode: Telephone no.: Mobile no.:

Hospital ID: Type of Hospital: Network ☐ Non Network ☐ If Non Network, provide below details

Registration No. with State Code: PAN: Number of Inpatient beds:

Facilities available in the hospital: OT: Yes: ☐ No: ☐ ICU: Yes: ☐ No: ☐

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: ANITA KUMARI

IP Registration no.: Gender: Male: ☐ Female: ☐ Age: 53 Years Month

Date of Birth: 10/03/1

Date of Admission: DD/MM/YYYY Time: HH:MM Date of Discharge: DD/MM/YYYY Time: HH:MM

Type of Admission: Emergency ☐ Planned ☐ Day Care ☐ Maternity ☐

Type of Treatment: Surgical Procedure ☐ Multiple Surgical Procedure ☐ Medical Treatment ☐

If Maternity, Date of Delivery: DD/MM/YYYY Gravida Status: G ☐ P ☐ A ☐ L ☐

Premature Baby: Yes: ☐ No: ☐

Status at time of discharge: Discharge to home ☐ Discharge to another hospital ☐ Deceased ☐

Total claimed amount:

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 ☐ No ☐ Reported to police: Yes ☐ No ☐

MLC Report & Police FIR attached: Yes ☐ No ☐ (If yes, attach report)

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**

A) Diagnosis (ICD 10 Code primary & additional dignosis)

i) Primary diagnosis (with ICD 10 code):

ii) Additional diagnosis (with ICD 10 code):

iii) Procedure diagnosis (with ICD 10 PCS code):

B) Nature of surgery/ treatment given for present ailment:

C) Date of first consultation (Prior to hospitalization):

D) Presenting complaints of the patient during admission:

E) Past medical history of the patient along with duration of illness
(If yes, attach first & all past consultation paper):

F) Was the patient under influence of alcohol during admission:

G) Whether the present treatment ailment is a complication of pre-existing disease ?:

i) If yes, please specify the disease (or) complication of any previous surgery done ?:

ii) If yes, please specify the details:

H) Whether the disease/ disorder is congenital in nature ?:

i) Number of in-patient beds in the hospital (including ICU):

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 (Rubber stamp of the hospital) Date: Doctor's Seal and Signature

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.

C1. Patient's Name: ANITA KUMARI

(in respect of whom claim is made)

C2. Policy Number: 4016/X/198469072/04/000

C3. Card No./ UHID No.: IL22265190603

C4. Group/Company Name (for Group/Corporate policy holders): Boeing India Pvt Ltd

C5. Claim Number (if allotted): **C6. Mobile/ Contact No.:** 87890919

☑ 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

♦ Proposer/ policy holder name*(as per bank records): ABHISHEK KUMAR SINGH

♦ Proposer/ policy holder Bank account no.: 50100172018364

♦ Name of the bank: HDFC BANK

♦ Branch name: GN CHETTY ROAD

♦ Address of the bank: No 56, 1st Floor, Gopathi Narayanaswami Chetty Rd, T. Nagar, Chennai, Tamil Nadu 600017

♦ IFSC code no. of the bank: HDFC0000206 (should be same as per the provided cheque leaflet)

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.

D1. Patient's Name: ANITA KUMARI

(in respect of whom claim is made)

D2. Policy Number: 4016/X/198469072/04/000

D3. Card No./ UHID No.: IL22265190603

D4. Group/Company Name (for Group/Corporate policy holders): Boeing India Pvt Ltd

D5. Claim Number (if allotted): **D6. Mobile/ Contact No.:** 878909199

D7. The below KYC documents are mandatory as per AML guidelines by IRDA

1. ☐ Two passport size photos of Proposer (stick in the space provided below)

2. ☐ One photocopy of proof of identity of Proposer (any 1 in the below list)

3. ☐ One photocopy of proof of residence of Proposer (any 1 in the below list)

☐ Passport

☐ PAN card

☐ Voter's Identity card

☐ Driving license

☐ Personal identification and certification of the employees of the insurer for identity of the prospective policyholder.

☐ Letter issued by Unique Identification Authority of India containing details of name, address and Aadhar number.

☐ Job card issued by NREGA duly signed by an officer of the State Government

☐ Letter from a recognized Public Authority (as defined under Section 2 (h) of the Right to Information Act, 2005) or Public Servant (as defined in Section 2(c) of the 'The Prevention of Corruption Act, 1988') verifying the identity and residence of the customer

☐ Electricity bill

☐ Ration card

☐ Letter from any recognized public authority

☐ Current statement of bank account with details of permanent/ present residence address (as downloaded)

☐ Current passbook with details of permanent/present residence address (updated upto the previous month)

☐ Valid lease agreement along with rent receipt, which is not more than three months old as a residence proof.

☐ Telephone bill pertaining to any kind of telephone connection like, mobile, landline, wireless, etc. provided it is not older than six months from the date of insurance contract

☐ Employer's certificate as a proof of residence (Certificates of employers who have in place systematic procedures for recruitment along with maintenance of mandatory records of its employees are generally reliable)

☐ Passport

☐ Written confirmation from the banks where the prospect is a customer, regarding identification and proof of residence.

☐ Current passbook with details of present/ permanent residence address (updated to the previous month)

☐ Current statement of Bank account with details of present/ permanent residence address (as downloaded)