

ICICI Lombard Health Care Claim Form - Hospitalisation

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



	Overview Health Claim Forr	n - Hospitalization	
	Part A	To be filled	Requirement
A1	Self Declaration		
A2	Self Declaration		
A3	Available in Policy Copy/ Employee details		
A4	Available in Policy Copy		
A5	Available in Discharge Summary	By insured/ insured	To track the policy and
A6	Self Declaration	relatives	other details of the insured
A7	Self Declaration		
A8	Available in Hospital Bills/ Self Declaration		
A9	Available in Hospital Bills		
A10	Checklist		
A11, Page end	Self declaration		
	Part B		
B1	Hospital Details		
B2	Doctor Details	To be filled by Hospital/	To track the hospital
В3	Patient details	Treating doctor	details and the treatment
B4	Treatment / Procedure Details		details related to the
B5	Required only for Retail/ Individual customers		patient admission
Page end	Hospital declaration		
	Part C		
C1	Patient's Name		
C2	Policy Number		
C3	Card No./UHID No.		For Electronic fund
C4	Group/ Company name	To be filled by Insured	transfer to the bank
C5	Claim number (if allotted)		account
C6	Mobile/ Contact no.		
C7	Provide any 1 document of proposer		
C8	As per bank pass book		
Page end	Account holder's signature		
C-KYC No.	Part D (Only for Retail/ Individual customers if claiming $> \ensuremath{\overline{\xi}}$ 1	lakh)	
Yes	Please provide, if Central KYC (C-KYC) no. available:	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	Y	N	Original
2.	Discharge Summary/ Daycare Summary	Y	N	Original
3.	Final Hospital Bill	Y	N	Original
4.	Payment Receipts	_Y_	N	Original
5.	Investigation Reports	Y	N	Original
6.	Pharmacy Bills	Y	N	Original
7.	Implant Sticker/ Invoice	Y	N	Original
8.	Doctor Prescriptions	Y	N	Photocopy
9.	Consultation Paper	Y	N	Photocopy
10.	Age Proof	Y	N	Photocopy
11.	Indoor Case Paper	Y	N	Photocopy
12.	EFT (Copy of cancelled cheque/ self attested ID poof/ Bank attested copy	VI	N. I	
	of passbook with IFSC code	Y	N	Photocopy
13.	Part D - CKYC FORM (Only for Retail/ Individual customers if claiming >₹ 1 lakh)	Y	N	Original



IRDA Registration No. 115



ICICI Lombard Health Care Claim Form - Hospitalisation



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

ALL CLAIM SETTLEMENTS SHOULD BE MADE THROUGH NEFT (AS PER IRDA CIRCULAR), PLEASE PROVIDE YOUR BANK ACCOUNT DETAILS. REFER TO PART C.

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→Claims→Health Claims→Services→Track your claims

TO BE FILLED IN CAPITAL LETTERS ONLY	pe filled by Insured)
	t 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:	
Card No./ UHID of the Patient:	
Gender: Male Female Date of Birth: D / M _	Completed age: Years — Months —
Occupation: Service Self Employed Homemaker Stud	ent Retired Other (Please specify)
Are you previously covered by any other Mediclaim/ Health Insura	
Current residential address:	
	City:
State:	Pin code:
Mobile no. Landline no.	
E-mail:	
A3. For Group/ Corporate Policy	For Individual/Retail Policy (*Mandatory
Member ID No./ Employee ID (Client ID):	*Claim Intimation Service Request no.:
	Is this a renewal policy: Yes No
Group/ Company name:	If Yes, kindly mention your previous policy no.:
A4. Name of the Proposer*:	
Relationship with Proposer*:	(*Policy Holder. For Retail policy, Proposer name required. For Corporate policy, provide Employee name)
Current Policy No.:	Card No./UHID:
A5. Nature of disease/illness contracted or injury suffered for whice	h Insured was hospitalized (Diagnosis):
Name of hospital where admitted:	
Room category occupied: Day care Single occupancy Twir	
Date of Admission: DD / MM / YYYY Time: HH:	
Date of injury sustained or disease/Illness first detected:	M/YYYY
If Injury, give cause: Self inflicted Road traffic accident Subs	• • • • • • • • • • • • • • • • • • • •
If Medico legal: Yes No Reported to police: Yes No No	MLC Report & Police FIR attached: Yes No (If yes, attach report)
System of Medicine:	
Is there any another claim in any of our policies towards the above inci	ident? Yes No If yes, provide AL/Claim No
A6. Are you covered under any Topup/Additional policy : Yes No_	If yes, provide policy no
A7. Currently covered by any other Mediclaim/ Health Insurance: $\underline{\hspace{1cm}}$	Date of commencement of first Insurance without break: DDM MY
Have you been hospitalized in the last 4 years since inception of contra	act: YN Date: DD / MM / YYYY Dignosis:
	sched 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: ₹	ii. Hospitalization expenses: ₹
iii. Post-hospitalization expenses: ₹	iv. Health-check up cost: ₹
v. Ambulance charges: ₹	vi. Others: ₹
	Total: ₹
vii Pre-hospitalization period	viii Post-hospitalization period: Days

b) Claim for																		
i. Domiciliary Hospitalization:	Yes	No _	∬(If yes	s, provid	e deta	ails ir	ann	exure)										
ii. Day care:	Yes	No_																
iii. Extended care/Inpatient rehabilitation:	Yes	No_																
c) Details of lump sum/ cash benefit claimed:																		
i. Hospital daily cash:	₹				ii.	Ma	atern	ity:				₹ _]_			
iii. Critical illness/PA/Donor Expenses:	₹		1 1		iv.	Со	nval	escenc	e:			₹						
v. Pre/Post hospitalization lump sum benefit:	₹	. رـــ رــ ا ا			vi.	Ωŧ	hers						/ 	 	_) 		
A9. Details of the amount claimed	`	J_J.			V1.	0.	1010.					` —			J)		
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Bill heads (as applicable) Room rent			BIII I	number		م ال م	BIII	iate Milyi	L v 1	Bills a		ea	=	1	_AN	noun	II	1
Doctors consultation/ Visit charges						ם ם מ	J M	M Y	Y J		N N		₹_	<u> </u>	<u> </u>	<u> </u>	<u> </u>	<u> </u>
Investigation charges (Includes Radiology and Pathology	v renorts)						I MI	M Y	Y		N I		₹	<u> </u>	<u></u>		<u> </u>	_
Surgeon and Asst. surgeon charges	у горопто/						IMI	MI YI	Y	Y	N I		₹		 	1	 	ا
Anesthetist charges & Operation theatre charges						o I o	I MI	MI YI	Y	Y	N		₹	<u> </u>)) <u> </u>	ر
Equipment charges/ Procedure charges							M	M Y	Υ	Υ	l N		₹	1		1		
Cost of implant (If any)							J M	MJ Y	Y	Υ	N J		₹	1]		1
Medicine charges (Includes ward and OT medicines and cor	nsumables)					M	M Y	Υ	Υ	N J		₹					j
Pharmacy charges						o J o	ј мј	мЈу	ΥĴ	Y	N		₹	J_				J
Taxes/ Surcharges/ Service charge						o] o] м]	мЈу	ΥĴ	_Y_	N		₹_]		J	
Miscellaneous/ Other charges						o J o	JMJ	MJ YJ	Υ	Y_	N		₹_		<u> </u>		<u> </u>	
Pre hospitalization bills (If any)						D D	J MJ	MJ Y	ΥJ	Υ	N		₹_					
Post hospitalization bills (If any)						D D	M	MJ Y J	Y	Y_	N		₹_					_
Discount provided by hospital (If any)						D D	M	M Y	Υ	Y	N)		₹_	<u> </u>	<u> </u>		<u> </u>	
	طه مه امینسم												₹					
Total claimed amount (In ₹) (Total claimed amount should be	e equai to tri	<u>e amou</u>	nt in atta	ched bill d	<u>ocume</u>	nts)												لــ
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▲ Your Claim details are just an SMS away, Please SMS <KEYWORD> to 57 57 58

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:
Address:
City: State: Sta
Pincode: Telephone no.: Mobile no.:
ROHINI ID: Type of Hospital: Network Non Network If Non Network, provide below details
Registration No. with State Code: PAN: Number of Inpatient beds: Number of Inpatient beds:
Facilities available in the hospital: OT: Y N ICU: Y N
B2. Details of the attending Medical Practitioner/ Doctor/ Treating Physician or Surgeon
Name:
Qualification: Registration no: Registration no:
Telephone no.: Mobile no.:
B3. Details of the patient admitted
Name of the patient:
IP Registration no.: Gender: MF Age: Years Months Date of Birth: DM_M_Y_Y_Y_Y_Y_Y_Y_Y_Y_Y_Y_Y_Y_Y_Y_Y_Y_Y
Date of Admission: DD/MM/YYYY Time: HHMM Date of Discharge: DD/MM/YYYY Time: HHMM
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: DD / MM / YYYY 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.



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

ALL CLAIM SETTLEMENTS SHOULD BE MADE THROUGH NEFT (AS PER IRDA CIRCULAR), PLEASE PROVIDE YOUR BANK ACCOUNT DETAILS.

C1. Patient's Name:					
C2. Policy Number:					
C3. Card No./ UHID No.					
C4. Group/Company Name (for Group/Corporate pol	icy holders):				
C5. Claim Number (if allotted):		C6. Mobile/ Conta	act No.:		
C7. Email:					
C8. As per IRDA Circular No.: IRDA/F&A/CII	R/GLD/056/02/2014, I	Proposer's/ policy h	older's bank account	details are mandatory to process th	10
claim through EFT.					
Please provide ANY ONE of the below docum	nents of proposer/po	licy holder-			
Please provide a self-attested copy of a v	alid Identity proof of th	e Proposer/Policy ho	lder (provide any of the mention	oned documents in Proof of Identity under Part-D)	
Cancelled cheque copy					
Bank attested copy of Passbook with IFS	C code				
C9. Please provide the below details (all field	ds are compulsory)				
Proposer (policy holder)/ Employee		rds):			
Proposer/ policy holder Bank account	1 1				
Name of the bank:					J
Branch name:					_
Address of the bank:					_
Address of the bulk.					_
IFSC code no. of the bank:			(should be same as per	the provided cheque leaflet)	_
PAN no. of Proposer:					
*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.

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 I imited
- 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
- 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.





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. 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. B) Please fill the form in English and in BLOCK letters. G) KYC number of applicant is mandatory for update application. C) Please fill the date in DD-MM-YYYY format. H) For particular section update, please tick (\checkmark) in the box available before the D) Please read section wise detailed guidelines / instructions at the end. 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) Prefix First Name Middle Name Last Name ☐ Name* (Same as ID proof) Maiden Name (If any*) Father / Spouse Name* Mother Name* Date of Birth* **РНОТО** Gender* ☐ M- Male F- Female ☐ T-Transgender Marital Status* Married Unmarried Others Others (ISO 3166 Country Code Citizenship* ☐ IN- Indian Residential Status* ☐ Resident Individual ■ Non Resident Indian ☐ Foreign National Person of Indian Origin \square S-Service (\square Private Sector Occupation Type* ☐ Public Sector ☐ Government Sector) \square O-Others (\square Professional ☐ Retired ☐ Housewife ☐Student) ☐ Self Employed □ 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 (Pol)* (Please refer instruction C at the end) (Certified copy of any one of the following Proof of Identity[Pol] needs to be submitted) D - M M - Y Y A- Passport Number Passport Expiry Date □ B- Voter ID Card C- PAN Card □ D- Driving Licence Driving Licence Expiry Date D ☐ 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. PRO	OF OF	ADD	RES	S (Po)*																											
☐ 4.1 CURF	RENT / P	ERMA	NEN	T / O\	/ERS	SEAS	ADDF	RES	S DE	ETAIL	_S (Plea	ase se	ee insti	ucti	on D	at th	ie en	d)													
(Certified copy	of <u>any o</u>	ne of	the fo	llowin	g Pr	oof of	Addre	ess [i	PoA]	nee	ds to	be	subm	itted)																		
Address Typ	e*	□ F	Resid	entia	ıl / B	usine	ess			Res	side	ntia	I			Bu	sine	ess				R	egis	stere	ed (Offic	е			□u	Insp	ecifie
Proof of Add	ress*		Passp /oter Simpl	Iden	,		s Acc	coun		NR	EG	A J	ence ob C ype	ard		_	D (A hers		aar)			pl	eas	e s	peci	fy			工		
Address								_		_		_				_			_	_			_	_	_		_	_		_	_	
Line 1*		\perp	\perp					<u> </u>			Щ	_					\perp	_	_	<u> </u>	Ш		_	_	<u> </u>	Щ	_	_	Ш	\Box	_	
Line 2																														Ш		
Line 3																				City	/ To	wn	/ V	illag	je*							
District*							Р	in / I	Post	Cod	de*					;	State	e/L	J.T (Coc	te*				ISO	310	66 C	Cour	ntry	Co	de*	

4.2 CORRESPOND	DENCE / LOCAL AI	DDRESS DETA	AILS * (Pl	ease see	e instruct	ion E at t	ne end)											
☐ Same as Current /	Permanent / Overs	seas Address d	etails (In	case of r	nultiple	orrespon	dence /	local	address	es, pl	ease f	'	nnex	ure A	1')			
Line 1*												<u> </u>						
Line 2										b. / Ta)	\ /:II	000*					
Line 3 District*		D	n / Post	Code*				State /	U.T C	-	own /	VIII 	-	316	6 Cou	ntry C	ode*	
District			1171 030	Oouc [riate i	0.10	ouc				010	0 000		,000	
4.3 ADDRESS IN T				PLICANT	_									plical	ole if se	ection 2	2 is tic	ked)
Same as Current /	Permanent / Overs	seas Address d	etails			Same as	Corres	sponde	ence / Lo	ocal A	ddress	de	tails					
Line 1*										+		\dashv						
Line 2									Cit	/ / To	wn / \	/illa	aue*					
State*						⊢_ ZIP / Po	st Cod	e*		y / 10		V 111C	_	3166	Cour	ntry C	ode*	
Oldio																- , -		
5. CONTACT DE	TAILS (All commun	nications will be s	ent on pro	vided														
T			Tel.	(Res)						M	obile							
FAX			Ema	il ID														
☐ 6. DETAILS OF R	RELATED PERSO	(In case of a	ıdditional re	elated per	rsons, ple	ase fill 'A	nnexure	B1')(please r	efer ins	structio	n G	at the	end)				
Addition of Related P	erson Deletion	of Related Per	son		KYO	Number	of Relat	ed Pers	son (if a	vailabl	e*)							
Related Person Type*		an of Minor		☐ Ass	ignee				rized R	epres	entati	ve			,			
Name*	Prefix		First Nam	ne 			I I	1iddle I	Name]			Last	Name	· 	
Name	(If KYC nun	mber and name	are provide	d, below	details of	section 6	are opti	onal) e	el. (Off)									
PROOF OF IDENTI	TV [Pol] OF RELATE	EN DERSON* (D	ا موء معدما	netruction	n (H) at th	e end)	-		· · ·									
☐ A- Passport Num		EDT EROOM (I		i i sti uctioi	i (ii) at ti	e ena)	Pag	enort	Expiry	Date		[D D	_ N	1 M -	- V V		v
☐ B- Voter ID Card	ibei						ı as	sport	<u> Г</u> хріі у	Date	•	l	0 0		101			
C- PAN Card																		
☐ D- Driving Licence	φ						Driv	dog Li	iaanaa	- Lynie	n. Doi		D D	1 6			/ L v L s	V
☐ E- UID (Aadhaar							DIII	ing L	icence	⊏xþii	у Ба	.е	υυ	- N	I IVI	1 1	T	T
F- NREGA Job C																		
☐ Z- Others (any do		the central gov	rernment)					lde	entifica	tion N	Jumb	er						
S- Simplified Mea				e				1	entifica			- 1	+			+		
7. REMARKS (If	any)			Mobile	e no. / Em	ail-ID) (Pl	ease ref	er instr	uction F	at the	end)							
														$\frac{1}{1}$				
8. APPLICANT								,										
 I hereby declare that the de therein, immediately. In case 																		
for it.															Thumb			
I hereby consent to receiving		_		ail on the at	oove registe	red number/	email addr	ess.				Si	anature	/ Thun	nh Imnre	ssion of	Annlica	ant
Date: DDD-M	M — Y Y Y Y		ice :									OI.	griature	7 mun	ib iilipie	331011 01	Applica	2111
9. ATTESTATION	N / FOR OFFICE	USE ONLY																
Documents Receive	d Certified (Copies																
KY	C VERIFICATION CA	ARRIED OUT B	′							INSTI	TUTIO	N D	ETAIL	S				
Date		_	7			Name												
Emp. Name						Code												
Emp. Code						Code												
Emp. Designation																		
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	[Employee S	Signature]									[INSULUI							

CENTRAL KYC REGISTRY | Instructons / Check list / Guidelines for filling Individual KYC Applicaton Form

General Instructions:

- 1 Fields marked with '*' are mandatory fields.
- 2 Tick **'** wherever applicable.
- 3 Self-Certfication of do cuments is mandatory.
- 4 Please fill the form in English and in BLOCK Leters.
- 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 updat ion of KYC details.
- 8 For part cular secton update, ple ase tck (🛭) in the box available before the secton number and strike o the sectons not required to be updated.
- 9 In case of 'Small Account type' only personal details at secton number 1 a nd 2, photograph, signature and self-certficaton required.

A Clarification / Guide lines 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 mentoned in the Pr oof of Identty submited 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 Clarificaton / Guide lines on filling details if applicant residence for tax purposes in jurisdicton(s) outside India

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

C Clarification / Guide lines 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 maindatorily furnished.
- Menton identification / reference number if 'Z Others (any document notified by the central government)' is tcked.
- 3 In case of Simplified Measures Accounts for verifying the identity of the applicant, any one of the following documents can also be submited and undernoted relevant code may be mentoned in point 3 (S).

code may be memorie	d in point 3 (3).
Document Code	Descripton
01	Identty card with app licant's photograph issued by Central/ State Government Departments, Statutory/ Regulatory Authorites, Pub lic Sector
	Undertakings, Scheduled Commercial Banks, and Public Financial Insttutons.
02	Leter i ssued by a gazeted o cer, with a duly atested photograph of the person.

O Clarificaton / Guide lines on filling 'Proof of Address [PoA] - Current / Permanent / Overseas Address deta ils' secton

- 1 PoA to be submited only if the submited 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 submited and undernoted relevant code may be mentoned in point 4.1.

oue may be memon	compone na
Document Code	Descripton
01	Utlity bi II which is not more than two months old of any service provider (ele ctricity, telephone, post -paid mobile phone, piped gas, water
	bill).
02	Property or Municipal Tax receipt.
03	Bank account or Post O ce savings bank account statement.
04	Pension or family pension payment orders (PPOs) i ssued to retred employees by Government Departments or Pub lic Sector Undertakings, i
	they contain the address.
05	Leter of a llotment of a ccommodaton from employer i ssued by State or Central Government departments, statutory or regulatory bodies
	public sector undertakings, scheduled commercial banks, financial insttutons and listed companies. Si milarly, leave and license agreement:
	with such employers allot ing o icial accommodaton.
06	Documents issued by Government departments of foreign jurisdictons and leter issued by Foreign Emba ssy or Mission in India.

E Clarification / Guide lines 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 submited.
- 2 In case of multple co rrespondence / local addresses, Please fill 'Annexure A1'

F Clarification / Guide lines on filling 'Contact details' section

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

G Clarificaton / Guide lines on filling 'Related Person details' secton

Provide KYC number of related person if available.

H Clarification / Guide lines on filling 'Related Person details – Proof of Identity [Pol] of Related Person' section

1 Menton identification / reference number if 'Z - Others (any document notified by the central government)' is tcked.

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

State / U.T	Code	State / U.T
Andaman & Nicobar	AN	Himachal Pradesh
Andhra Pradesh	AP	Jammu & Kashmir
Arunachal Pradesh	AR	Jharkhand
Assam	AS	Karnataka
Bihar	BR	Kerala
Chandigarh	CH	Lakshadweep
Chat sgarh	CG	Madhya Pradesh
Dadra and Nagar Haveli	DN	Maharashtra
Daman & Diu	DD	Manipur
Delhi	DL	Meghalaya
Goa	GA	Mizoram
Gujarat	GJ	Nagaland
Haryana	HR	Orissa
пагуана	пк	Ulissa

State / U.T	Code
Pondicherry	PY
Punjab	PB
Rajasthan	RJ
Sikkim	SK
Tamil Nadu	TN
Telangana	TS
Tripura	TR
Utar Pra desh	UP
Utarakhand	UA
West Bengal	WB
Other	XX

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	PM
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 Andorra	AS AD	Equatorial Guinea Eritrea	GQ ER	Macao Macedonia, the former Yugoslav Republic	MO MK	Sao Tome and Principe Saudi Arabia	ST SA
Avenda	AO	Estania	EE	of	MG	Canada	SN
Angola		Estonia		Madagascar		Senegal	
Anguilla	AI	Ethiopia	ET	Malawi	MW	Serbia	RS
Antarctca	AQ	Falkland Islands (Malvinas)	FK	Malaysia	MY	Seychelles	SC
Antgua and Barbuda	AG	Faroe Islands	FO	Maldives	MV	Sierra Leone	SL
Argentna	AR	Fiji	FJ	Mali	ML	Singapore	SG
Armenia	AM	Finland	FI	Malta	MT	Sint Maarten (Dutch part)	SX
Aruba	AW	France	FR	Marshall Islands	MH	Slovakia	SK
Australia	AU	French Guiana	GF	Martni que	MQ	Slovenia	SI
Austria	AT	French Polynesia	PF	Mauritania	MR	Solomon Islands	SB
Azerbaijan	AZ	French Southern Territories	TF	Mauritus	MU	Somalia	SO
Bahamas	BS	Gabon	GA	Mayote	YT	South Africa	ZA
Bahrain	BH	Gambia	GM		MX	South Georgia and the South Sandwich	GS
banrain	ВП	Gambia	GIVI	Mexico	IVIX	Islands	GS
Bangladesh	BD	Georgia	GE	Micronesia, Federated States of	FM	South Sudan	SS
Barbados	BB	Germany	DE	Moldova, Republic of	MD	Spain	ES
Belarus	BY	Ghana	GH	Monaco	MC	Sri Lanka	LK
Belgium	BE	Gibraltar	GI	Mongolia	MN	Sudan	SD
Belize	BZ	Greece	GR	Montenegro	ME	Suriname	SR
Benin	BJ	Greenland	GL	Montserrat	MS	Svalbard and Jan Mayen	SJ
Bermuda	BM	Grenada	GD	Morocco	MA	Swaziland	SZ
Bhutan	BT	Guadeloupe	GP	Mozambique	MZ	Sweden	SE
Bolivia, Plurinat onal State of	BO	Guam	GU	Myanmar	MM	Switzerland	CH
Bonaire, Sint Eustatus and Saba	BQ	Guatemala	GT	Namibia	NA	Syrian Arab Republic	SY
Bosnia and Herzegovina	BA	Guernsey	GG	Nauru	NR	Taiwan, Province of China	TW
Botswana	BW	Guinea	GN	Nepal	NP	Tajikistan	TJ
Bouvet Island	BV		GW	Netherlands	NL		TZ
		Guinea-Bissau				Tanzania, United Republic of	
Brazil	BR	Guyana	GY	New Caledonia	NC	Thailand	TH
Britsh I ndian Ocean Territory	10	Hait	HT	New Zealand	NZ	Timor-Leste	TL
Brunei Darussalam	BN	Heard Island and McDonald Islands	HM	Nicaragua	NI	Togo	TG
Bulgaria	BG	Holy See (Vatcan City State)	VA	Niger	NE	Tokelau	TK
Burkina Faso	BF	Honduras	HN	Nigeria	NG	Tonga	TO
Burundi	BI	Hong Kong	HK	Niue	NU	Trinidad and Tobago	TT
Cabo Verde	CV	Hungary	HU	Norfolk Island	NF	Tunisia	TN
Cambodia	KH	Iceland	IS	Northern Mariana Islands	MP	Turkey	TR
Cameroon	CM	India	IN	Norway	NO	Turkmenistan	TM
	CA		ID	Oman	OM	Turks and Caicos Islands	TC
Canada		Indonesia					
Cayman Islands	KY	Iran, Islamic Republic of	IR	Pakistan	PK	Tuvalu	TV
Central African Republic	CF	Iraq	IQ	Palau	PW	Uganda	UG
Chad	TD	Ireland	IE	Palestne, State of	PS	Ukraine	UA
Chile	CL	Isle of Man	IM	Panama	PA	United Arab Emirates	AE
China	CN	Israel	IL	Papua New Guinea	PG	United Kingdom	GB
Christmas Island	CX	Italy	IT	Paraguay	PY	United States	US
Cocos (Keeling) Islands	CC	Jamaica	JM	Peru	PE	United States Minor Outlying Islands	UM
Colombia	CO	Japan	JP	Philippines	PH	Uruguay	UY
	KM		JE	Pitcairn	PN	Uzbekistan	UZ
Comoros		Jersey					VU
Congo, the Democrato Republic of	CG CD	Jordan Kazakhstan	JO KZ	Poland Portugal	PL PT	Vanuatu Venezuela, Bolivarian Republic of	VU VE
the							
Cook Islands	CK	Kenya	KE	Puerto Rico	PR	Viet Nam	VN
Costa Rica	CR	Kiribat	KI	兡t 慲	QA	Virgin Islands, 籍itsh	VG
Cote d'Ivoire !Côte d'Ivoire	CI	Korea, Democrat c People's Republic of	KP	Reunion !Réunion	RE	Virgin Islands, U.S.	VI
Croata	HR	Korea, Republic of	KR	Romania	RO	Wallis and Futuna	WF
Cuba	CU	Kuwait	KW	Russian Federaton	RU	Western Sahara	EH
Curacao !Curaçao	CW	Kyrgyzstan	KG	Rwanda	RW	Yemen	YE
Cyprus	CY	Lao People's Democrat c Republic	LA	Saint Barthelemy !Saint Barthélemy	BL	Zambia	ZM
Czech Republic	CZ	Latvia	LV	Saint Helena, Ascension and Tristan da Cunha	SH	Zimbabwe	ZW
Denmark	DK	Lebanon	LB	Saint Kits and Nevis	KN		
Djibout	DJ	Lesotho	LS	Saint Lucia	LC		
Dominica	DM	Liberia	LR	Saint Martn (French part)	MF		

Annexure A1 CENTRAL KYC REGISTRY | Know Your Customer (KYC) Application Form | Individual | Correspondence / Local Address

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 (\checkmark) in the box available before the section number and strike off the sections not required to be updated.

For office use only	Application Type*	□ New □ U	pdate			
(To be filled by financial institution)	KYC Number				(Mandatory	for KYC update request)
1. CORRESPONDENCE	LOCAL ADDRESS DE	ETAILS (Plea	ase see instruction	E at the end)	1	
☐ Same as Current / Permanent /	Overseas Address details					
Line 1*						
Line 2						
Line 3					City / Town /	Village*
District*	Pin / P	ost Code*		State / U.	, -	ISO 3166 Country Code*
2. CONTACT DETAILS (All co	ommunications will be sent o	n provided Mobil	e no./ Email-ID) (Plea	ase refer instru	uction F at the en	d) el. (Off)
T CONTACT DETAILS (All or	ommunications will be sent o	n provided Mobil	e no./ Email-ID) (Plea	ase refer instru	uction F at the en	
·			e no./ Email-ID) (Plea	ase refer instru		
т		Tel. (Res)	e no./ Email-ID) (Plea	ase refer instru		
т		Tel. (Res)	e no./ Email-ID) (Plea	ase refer instru		
TFAX	TION bove are true and correct to the besi	Tel. (Res) Email ID	d belief and I undertake to	o inform you of any	Mobile Mobile y changes	
T FAX 3. APPLICANT DECLARA • I hereby declare that the details furnished a therein, immediately. In case any of the about the details furnished and therein, immediately. In case any of the about the details furnished and therein, immediately. In case any of the about the details furnished and the det	TION bove are true and correct to the besi	Tel. (Res) Email ID	d belief and I undertake to	o inform you of any	Mobile Mobile y changes	
T FAX 3. APPLICANT DECLARA • I hereby declare that the details furnished a therein, immediately. In case any of the about liable for it.	TION Dove are true and correct to the bestore information is found to be false	Tel. (Res) Email ID	d belief and I undertake to	o inform you of any	Mobile Mobile y changes	[Signature / Thumb Impression]
T FAX 3. APPLICANT DECLARA • I hereby declare that the details furnished a therein, immediately. In case any of the about the details furnished and therein, immediately. In case any of the about the details furnished and therein, immediately. In case any of the about the details furnished and the det	TION bove are true and correct to the besi	Tel. (Res) Email ID	d belief and I undertake to	o inform you of any	Mobile Mobile y changes	

Annexure B1

CENTRAL KYC REGISTRY | Know Your Customer (KYC) Application Form | Individual | Related Person

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 of the sections not required to be updated.

For office use only	Application Type* ☐ New ☐ Update
(To be filled by financial institu	ution) KYC Number (Mandatory for KYC update request)
□ 1 DETAILS OF BELAT	ED PERSON (Please refer instruction G at the end)
Addition of Related Person Related Person	□ Deletion of Related Person KYC Number of Related Person (if available*) □ Type* □ Guardian of Minor □ Assignee □ Authorized Representative
Related Ferson	Prefix First Name Middle Name Last Name
Name*	
	(If KYC number and name are provided, below details of section 1 are optional)
PROOF OF IDENTITY (Pol) OF RELATED PERSON* (Please see instruction (H) at the end)
☐ A- Passport Number	Passport Expiry Date DDDMM—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 documen	t notified by the central government)
☐ S- Simplified Measures	s Account - Document Type code Identification Number
2. APPLICANT DECL	ARATION
	nished above are true and correct to the best of my knowledge and belief and I undertake to inform you of any changes
liable for it.	the above information is found to be false or untrue or misleading or misrepresenting, I am aware that I may be held [Signature / Thumb Impression]
Date : DD - MM -	Y Y Y Y Place : Signature / Thumb Impression of Applicant
3. ATTESIATION / FO	R OFFICE USE ONL Y
Documents Received	Certified Copies
KYC VER	FICATION CARRIED OUT BY INSTITUTION DETAILS
Date	Name Name
Emp. Name	Code
Emp. Code	
Emp. Designation	
Emp. Branch	
	[Institution Stamp]
	[Employee Signature]



ICICI Lombard General Insurance Company limited

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

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

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