ICICI Lombard Health Care Claim Form - Hospitalisation

(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	Self Declaration	By insured/ insured relatives	To track the policy and other details of the insured
A2	Self Declaration		
A3	Available in Policy Copy/ Employee details		
A4	Available in Policy Copy		
A5	Available in Discharge Summary		
A6	Self Declaration		
A7	Self Declaration		
A8	Available in Hospital Bills/ Self Declaration		
A9	Available in Hospital Bills		
A10	Checklist		
A11	Self declaration		
A12	ETF details		
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		
C-KYC No.	**Part C (Only for Retail/ Individual customers if claiming >₹ 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 of passbook with IFSC code	Y	N	Photocopy
13.	Part D - C-KYC Form (Only for Retail/ Individual customers if claiming >₹ 1 lakh)	Y	N	Original
14.	**Mask first 8 digits of your Aadhaar Card ^ Copy of the Proposer/ Employee**	Y		Photocopy
15.	**PAN Card Copy of the Proposer/ Employee (Mandatory)**	Y		**Photocopy**

^ Mask first 8 digits of your aadhaar number in claim form and claim documents submitted.

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

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).

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

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:

Card No./ UHID of the Patient:

Gender: Male ☐ Female ☐ Transgender ☐ Date of Birth: D D / M M / Y Y Y Y Completed age: Years ☐☐ 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:

City:

State: Pin code:

Mobile no. Landline no.

E-mail:

Covid Vaccination Status: Yes ☐ No ☐ **Name of the Vaccination** Covishield ☐ Covaxin ☐ Sputnik ☐ Others ☐ _____

Dosage of Vaccination: 1st Dose ☐ 2nd Dose ☐

A3. For **Group/ Corporate** Policy

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

Group/ Company name:

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/Employee:

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 which Insured was hospitalized (Diagnosis): _____

Name of hospital where admitted:

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

Date of Admission: D D / M M / Y Y Y Y Time: H H : M M Date of Discharge: D D / M M / Y Y Y Y Time: H H : M M

Date of injury sustained or disease/ Illness first detected: D D / M M / Y Y Y Y

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: _____

Is there any another claim in any of our policies towards the above incident? 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: Y N Date of commencement of first Insurance without break: D D M M Y Y

Have you been hospitalized in the last 4 years since inception of contract: Y N Date: D D / M M / Y Y Y Y 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: _____ 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 ☐☐☐ Days viii. Post-hospitalization period: ☐☐☐ Days

b) Claim for

i. Domiciliary Hospitalization: Yes ☐ No ☐ 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. 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		D D M M Y Y	Y N	₹
Doctors consultation/ Visit charges		D D M M Y Y	Y N	₹
Investigation charges (Includes Radiology and Pathology reports)		D D M M Y Y	Y N	₹
Surgeon and Asst. surgeon charges		D D M M Y Y	Y N	₹
Anesthetist charges & Operation theatre charges		D D M M Y Y	Y N	₹
Equipment charges/ Procedure charges		D D M M Y Y	Y N	₹
Cost of implant (If any)		D D M M Y Y	Y N	₹
Medicine charges & Pharmacy charges		D D M M Y Y	Y N	₹
Taxes/ Surcharges/ Miscellaneous/Service charge/ Other charges/ Discount provided by hospital (If any)		D D M M Y Y	Y N	₹
Pre hospitalization bills & Post hospitalization bills (If any)		D D M M Y Y	Y N	₹

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

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*	Y	N	8. Cancelled cheque (for bank account details)	Y	N
2. Discharge summary*	Y	N	9. ICICI Lombard GIC Authorisation Letter	Y	N
3. Hospital bills, Final/ main hospital bill and other bills (if any)*	Y	N	10. Implant name and invoice (if any) with implant sticker	Y	N
4. Hospital payment receipt & other receipts supporting bills*	Y	N	11. Indoor Case Papers	Y	N
5. Investigation reports* (Including ECG/ CT/ MRI/ USG/ HPE)	Y	N	12. Prescription papers/ Consultation papers	Y	N
6. Medicine/ Pharmacy bills with doctors prescription*	Y	N	13. C-KYC FORM (Only for Retail/Individual customers, claiming > ₹ 1Lakh)	Y	N
7. Age proof (Driving License/ PAN card/ Passport/ Aadhaar copy^)*	Y	N	14. Others (details) _____	Y	N

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)

A12. Please provide the below details (all fields are compulsory)

- Proposer (policy holder)/ Employee name*(as per bank records): _
- Proposer/ policy holder Bank account no.: _
- Name of the bank: _
- Branch name: _
- IFSC code no. of the bank: _ _ _ _ _ _ _ _ _ _ _ PAN No. of the Proposer: _ _ _ _ _ _ _ _ _ _

***Please provide a Cancelled cheque of account holder.**

***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.

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: D D / M M / Y Y Y Y Place: _____ Insured's Signature: _____

^ Mask first 8 digits of your aadhaar number in claim form and claim documents submitted.

क्लेम फॉर्म हिन्दी के लिए कृपया हमारी वेबसाइट पर जाँच कीजिए : **www.icicilombard.com**

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

Your Claim details are just an SMS away, Please SMS <KEYWORD> to 57 57 58

• Cashless Status: <KEYWORD> is "ILHC AL <12-digit-AL-No.>" • Claim Status: <KEYWORD> is "ILHC CL <12-digit-CL-No.>" • Payment details: <KEYWORD> is "ILHC PAY <12-digit-Claim-No.>"

(AL No. & CL No. is the one you have received on your mobile no. after intimating us)

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:

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:

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:

Telephone no.: Mobile no.:

B3. Details of the patient admitted

Name of the patient:

IP Registration no.: Gender: M F T Age: Years Months Date of Birth: D D M M Y Y Y Y

Date of Admission: D D / M M / Y Y Y Y Time: H H : M M Date of Discharge: D D / M M / Y Y Y Y Time: H H : M M

Type of Admission: Emergency Planned Day Care Maternity

Type of Treatment: Surgical Procedure Multiple Surgical Procedure Medical Treatment

If Maternity, Date of Delivery: D D / M M / Y Y Y Y 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: D D / M M / Y Y Y Y

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: D D / M M / Y Y Y Y

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 - 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)

	Prefix	First Name	Middle Name	Last Name
☐ Name* (Same as ID proof)				
Maiden Name (If any*)				
Father / Spouse Name*				
Mother Name*				

Date of Birth* D D – M M – Y Y Y Y

PHOTO

Gender* ☐ M- Male ☐ F- Female ☐ T-Transgender

Marital Status* ☐ Married ☐ Unmarried ☐ Others

Citizenship* ☐ IN- Indian ☐ Others (ISO 3166 Country Code ☐☐)

Residential Status* ☐ Resident Individual ☐ Non Resident Indian ☐ Foreign National ☐ Person of Indian Origin

Occupation Type* ☐ S-Service (☐ Private Sector ☐ Public Sector ☐ Government Sector) ☐ O-Others (☐ Professional ☐ Self Employed ☐ Retired ☐ Housewife ☐ Student) ☐ B-Business ☐ X- Not Categorised

Signature / Thumb Impression

☐ 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 <u>any one</u> of the following Proof of Identity[PoI] needs to be submitted)

☐ A- Passport Number _____ Passport Expiry Date D D – M M – Y Y Y Y

☐ B- Voter ID Card _____

☐ C- PAN Card _____

☐ D- Driving Licence _____ Driving Licence Expiry Date D D – M M – Y Y Y Y

☐ 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 <u>any one</u> 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 _____ please specify ☐ 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* ☐☐

^ Mask first 8 digits of your aadhaar number in claim form and claim documents submitted.

☐ 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 3 City / Town / Village*

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

	Prefix	First Name	Middle Name	Last Name
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 D D – M M – Y Y Y Y

☐ B- Voter ID Card

☐ C- PAN Card

☐ D- Driving Licence Driving Licence Expiry Date D D – M M – Y Y Y Y

☐ 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.

Date : D D – M M – Y Y Y Y Place :

[Signature / Thumb Impression]

Signature / Thumb Impression of Applicant

9. ATTESTATION / FOR OFFICE USE ONLY

Documents Received ☐ Certified Copies

KYC VERIFICATION CARRIED OUT BY

Date D D – M M – Y Y Y Y

Emp. Name

Emp. Code

Emp. Designation

Emp. Branch

[Employee Signature]

INSTITUTION DETAILS

Name

Code

[Institution Stamp]

^ Mask first 8 digits of your aadhaar number in claim form and claim documents submitted.

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 (✓) 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 [PoI]' 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 PoI does not have an address or address as per PoI 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
Andaman & Nicobar	AN
Andhra Pradesh	AP
Arunachal Pradesh	AR
Assam	AS
Bihar	BR
Chandigarh	CH
Chattisgarh	CG
Dadra and Nagar Haveli	DN
Daman & Diu	DD
Delhi	DL
Goa	GA
Gujarat	GJ
Haryana	HR

State / U.T	Code
Himachal Pradesh	HP
Jammu & Kashmir	JK
Jharkhand	JH
Karnataka	KA
Kerala	KL
Lakshadweep	LD
Madhya Pradesh	MP
Maharashtra	MH
Manipur	MN
Meghalaya	ML
Mizoram	MZ
Nagaland	NL
Orissa	OR

State / U.T	Code
Pondicherry	PY
Punjab	PB
Rajasthan	RJ
Sikkim	SK
Tamil Nadu	TN
Telangana	TS
Tripura	TR
Uttar Pradesh	UP
Uttarakhand	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	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
Argentina	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	Martinique	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	Mayotte	YT	South Africa	ZA
Bahrain	BH	Gambia	GM	Mexico	MX	South Georgia and the South Sandwich 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 Eustatius 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	Guinea-Bissau	GW	Netherlands	NL	Tanzania, United Republic of	TZ
Brazil	BR	Guyana	GY	New Caledonia	NC	Thailand	TH
Britsh I ndian Ocean Territory	IO	Haiti	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
Canada	CA	Indonesia	ID	Oman	OM	Turks and Caicos Islands	TC
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	Palestine, 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
Comoros	KM	Jersey	JE	Pitcairn	PN	Uzbekistan	UZ
Congo	CG	Jordan	JO	Poland	PL	Vanuatu	VU
Congo, the Democratc Republic of the	CD	Kazakhstan	KZ	Portugal	PT	Venezuela, Bolivarian Republic of	VE
Cook Islands	CK	Kenya	KE	Puerto Rico	PR	Viet Nam	VN
Costa Rica	CR	Kiribati	KI	Qatar	QA	Virgin Islands, British	VG
Cote d'Ivoire !Côte d'Ivoire	CI	Korea, Democratic 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 Democratic 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 Martin (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 (✓) in the box available before the section number and strike off the sections not required to be updated.

For office use only
(To be filled by financial institution)

Application Type* ☐ New ☐ Update

KYC Number _____ *(Mandatory for KYC update request)*

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

☐ Same as Current / Permanent / Overseas Address details

Line 1*

Line 2

Line 3 City / Town / Village*

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

☐ 2. CONTACT DETAILS (All communications will be sent on provided Mobile no./ Email-ID) (Please refer instruction **F** at the end)

Tel. (Off) – Tel. (Res) – Mobile –

FAX – Email ID

3. 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.

[Signature / Thumb Impression]

Signature / Thumb Impression of Applicant

Date : D D – M M – Y Y Y Y

Place :

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 off the sections not required to be updated.

For office use only *(To be filled by financial institution)*
Application Type* ☐ New ☐ Update
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* Prefix _____ First Name _____ Middle Name _____ Last Name _____

(If KYC number and name are provided, below details of section 1 are optional)

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

☐ A- Passport Number _____ Passport Expiry Date D D – M M – Y Y Y Y
☐ B- Voter ID Card _____
☐ C- PAN Card _____
☐ D- Driving Licence _____ Driving Licence Expiry Date D D – M M – Y Y Y Y
☐ 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.

[Signature / Thumb Impression]

Signature / Thumb Impression of Applicant

Date : D D – M M – Y Y Y Y Place : _____

3. ATTESTATION / FOR OFFICE USE ONL Y

Documents Received ☐ Certified Copies

KYC VERIFICATION CARRIED OUT BY

Date D D – M M – Y Y Y Y
Emp. Name _____
Emp. Code _____
Emp. Designation _____
Emp. Branch _____

[Employee Signature]

INSTITUTION DETAILS

Name _____
Code _____

[Institution Stamp]

^ Mask first 8 digits of your aadhaar number in claim form and claim documents submitted.

ICICI Lombard
Nibhaye Vaade
ICICI Lombard General Insurance Company limited
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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

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