ICICI Lombard Health Care Claim Form - Hospitalisation

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

ICICI Lombard Health Care

Overview Health Claim Form - Hospitalization

	Part A	To be filled	Requirement
A1	Type of Claim- To be filled by Insured	By insured/ insured relatives	To track the policy and other details of the insured
A2	Details of the insured person-To be filled by Insured		
A3	Available in Policy Copy/ Employee details		
A4	Available in Policy Copy		
A5	Available in Discharge Summary		
A6	Other policy coverages		
A7	Currently covered by any other mediclaim		
A8	Available in Hospital Bills/ Self Declaration		
A9	Available in Hospital Bills		
A10	Checklist		
A11	Reason of delay-To be filled by Insured		
Page end	Self declaration		
	Part B		
B1	Hospital Details	To be filled by Hospital/ Treating doctor	To track the hospital details and the treatment details related to the patient admission
B2	Doctor Details		
B3	Patient details		
B4	Treatment / Procedure Details		
B5	Required only for Retail/ Individual Customers		
Page end	Hospital declaration		
	Part C		
C1	EFT Details	Copy of cancelled cheque/Copy of passbook or bank statement with Payee/account holders name and IFSC code	
C-KYC No.	**(Only for Retail/ Individual customers for all claims)**		
Yes	Please provide, if Central KYC (C-KYC) no. available:	To be filled by Insured	As per IRDA, C-KYC is mandate for for all claims
	_ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _		
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.	**ICICI Lombard Health card**	Y	N	**Original**
4.	**Final Hospital Bill**	Y	N	**Original**
5.	**Payment Receipts**	Y	N	**Original**
6.	**Investigation Reports**	Y	N	**Original**
7.	**Pharmacy Bills**	Y	N	**Original**
8.	**Implant Sticker/ Invoice**	Y	N	**Original**
9.	**EFT (Copy of cancelled cheque/Copy of passbook or bank statement with Payee/account holders name and IFSC code)**	Y	N	**Photocopy**
10	Consultation Paper	Y	N	Photocopy
11.	Age Proof	Y	N	Photocopy
12.	Indoor Case Paper	Y	N	Photocopy
13.	Doctor Prescriptions	Y	N	Photocopy
14.	C-KYC Form (Only for Retail/ Individual customers for all claims)	Y	N	Original
15.	**PAN Card Copy of the Proposer/ Employee (Mandatory if claim amount is greater than 1 lakh)**	Y		**Photocopy**

Mailing Address: ICICI Lombard Healthcare, Varun Tower II, 1st, 4th, 5th & 6th Floor, Begumpet, Hyderabad, Telangana, Pincode – 500016.
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

12/11/2024/0001

ICICI Lombard
Nibhaye Vaade

ICICI Lombard Health Care Claim Form - Hospitalisation

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

ICICI Lombard Health Care

Do You Know

- ★ Non-submission of bills and receipts is the main reason for delay in claim settlements. Please provide all mandatory documents.
- ★ To receive updates on your claim status, do provide your WhatsApp enabled mobile number & your E-mail address.
- ★ You can track your claim by downloading the ILTake Care App, on WhatsApp just say 'Hi' to RIA on 7738282666 or on our Website at www.icicilombard.com, simply navigate to Claims > Health 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: FIRST MIDDLE LAST

Card No./ UHID of the Patient:

Gender: Male ☐ Female ☐ Transgender ☐ Date of Birth: DD / MM / YYYY 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:

ABHA Number

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

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. Diagnosis as per discharge summary: _____

Name of hospital where admitted:

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

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

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)

System of Medicine: ☐ Allopathy ☐ AYUSH

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: YN Date of commencement of first Insurance without break: DD MM YY

Have you been hospitalized in the last 4 years since inception of contract: YN Date: DD / MM / YYYY Dignosis: _____

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

Company name: _____ 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/Service		D D M M Y Y	Y N	₹
Discount provided by Hospital/Miscellaneous charges		D D M M Y Y	Y N	₹
Other TPA/Insurance settled amount		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)				₹

Mandatory: All claim settlements must be processed through NEFT (as per regulatory norms). Please provide your bank account details along with a copy of a cancelled cheque/passbook or a bank statement showing the payee/account holder's name and IFSC code.

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

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

Kindly **do not** furnish **Aadhaar card** and send any other document for id proof

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

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

Provide Details (If Applicable)

Declaration by the Insured:

For your better well-being, we will be using your diagnosis reports, personal and other health data and information with our health coaches as we will be following up on a regular basis. Yes ☐ No ☐

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

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

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

Claim documents to be dispatched to: ICICI Lombard Healthcare, Varun Tower II, 1st, 4th, 5th & 6th Floor, Begumpet, Hyderabad, Telangana, Pincode – 500016.

In case the policy is serviced by external TPA, please dispatch the claim documents to respective TPAs.

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 homein 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.

ICICI Lombard
Nibhaye Vaade

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

Mandatory: All claim settlements must be processed through NEFT (as per regulatory norms). Please provide your bank account details along with a copy of a cancelled cheque/passbook or a bank statement showing the payee/account holder's name and IFSC code Please provide your consent to credit ₹1 to your bank account mentioned in the grid below for claim processing.

C1. Patient's Name: (in respect of whom claim is made):

C2. PAN No. of the Proposer **(Mandatory if claim amount is greater than 1 lakh)**

C3. Card No./ UHID No.:

C4. Claim Number (if allotted):

C5. Mobile/ Contact No.:

C6. Email:

C7. As per IRDA Circular No.: IRDA/F&A/CIR/GLD/056/02/2014, Proposer's/ Policy holder's bank account details are mandatory to process the claim through EFT.

Please provide below documents of Proposer/ Policy holder-

- ☐ Please provide a self-attested copy of a valid Identity proof of the Proposer/Policy holder (provide any of the mentioned documents in Proof of Identity under Part-D)
- ☐ Cancelled cheque copy/ Bank attested copy of Passbook with IFSC code

C8. 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:
- Address of the bank:
- IFSC code no. of the bank: (should be same as per the provided cheque leaflet)
- PAN No. of the 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 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.

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 for all claims.

To be filled by Proposer: KYC Number *(Mandatory for KYC update request)*

If KYC Number is not available, please fill this Central-KYC (C-KYC) form

☐ 1. PERSONAL DETAILS

	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

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

PHOTO

Signature / Thumb Impression

☐ 2. PROOF OF IDENTITY (PoI)* (Please refer instruction C at the end)

(Certified copy of any one of the following Proof of Identity[PoI] needs to be submitted)

☐ A-Passport Number — Passport Expiry Date 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

☐ 3. PROOF OF ADDRESS (PoA)*

CURRENT / PERMANENT / OVERSEAS ADDRESS DETAILS (Please see instruction at the end)

(Certified copy of any one of the following Proof of Address [PoA] needs to be submitted)

Address Type* ☐ Residential / Business ☐ Residential ☐ Business ☐ Registered Office ☐ Unspecified

Proof of Address* ☐ Passport ☐ Driving Licence ☐ UID (Aadhaar^)
☐ Voter Identity Card ☐ NREGA Job Card ☐ Others 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.

Account Holder's Signature

ICICI Lombard
Nibhaye Vaade

Mailing Address: ICICI Lombard Healthcare, Varun Tower II, 1st, 4th, 5th & 6th Floor, Begumpet, Hyderabad, Telangana, Pincode – 500016.
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

12/11/2024/0001

Consent letter

To Whomsoever It May Concern

Subject: Consent for Collection of Medical Records

Proposal No. / Policy No.: <PolicyNo. / Proposal No.>

I / We, the undersigned, hereby authorise ICICI Lombard General Insurance Company Ltd. to collect all relevant documents and medical records related to hospitalisation or medical treatment of Insured Person(s) covered under the above-mentioned policy from the Hospital or Medical Practitioner.

I/We have no objection to sharing my/our hospitalization documents with ICICI Lombard for the purpose of processing claims under the policy.

Please note: *In case any original hospitalization or day-care treatment-related documents were collected by you at the time of discharge but were not submitted during the claim process, kindly ensure their submission to enable us to process the claim as per the policy terms and conditions.*

Additionally, please send us a self-attested copy of a valid government-issued identity proof of the Claimant/Insured along with this consent letter.

Thank you for your assistance and cooperation.

Sincerely,
Team ICICI Lombard.

_____ _____

Name of the Insured Claimant / Insured Signature

12/11/2024/0001