ICICI Lombard
GENERAL INSURANCE

ICICI LOMBARD GENERAL INSURANCE COMPANY LIMITED

Regd. Office: ICICI Towers, Bandra Kurla Complex, Bandra (East), Mumbai – 400 051

CLAIM FORM FOR GROUP MEDICLAIM POLICY

(The issue of this form is not to be taken as an Admission of Liability)
Please give the following information correctly and completely.

Claim No.

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1.	Name of the Insured:	
(i)	Name of the Insured Employee	
(ii)	Salary Roll No.	
(iii)	E-mail id	
(iv)	Policy No.	
2. (i) (ii) (iii) (iv)	Details of the Insured Person in respect of whom claim is made: If family member, name & relationship to the insured employee: Present completed age Occupation: Residential address	
3.	Nature of disease / illness contracted or injury suffered:	
4.	Date of injury sustained or disease / illness first detected	
5.(i) (ii) (iii)	Name and address of the hospital / Nursing Home / Clinic Date of admission Date of discharge:	
6. (i) (ii)	Amount of Pre and Post Hospitalisation Expenses incurred Total Amount Claimed	
6. (i) (ii) (iii)	If the claim is for domiciliary hospitalization, please indicate: Date of commencement of treatment Date of completion of treatment Name & address of attending Medical	

(iv) (v)	Practitioner Qualification Telephone No.	

In support of the above claim, I enclose following documents {Please indicate by (✔)}

1. Bills, Receipt and Discharge Certificate / card from the Hospital/Nursing Home.
2. Cash memos from the Hospital / Chemist(s), supported by the proper prescription.
3. Receipt and Pathological test reports from a Pathologist supported by the note from the attending Medical Practitioner / Surgeon demanding such Pathological tests.
4. Surgeons certificate stating nature of operation performed and surgeon's bill and receipt.
5. Attending Doctor's / Consultant's / Specialist's / Anesthetist's bill and receipt and certificate regarding diagnosis, whichever is prescribed & thereby expenses incurred

Declaration

I hereby agree, affirm and declare that:

(a) The statements/information given/stated by me/us in this claim form are true, correct and complete.

(b) No material information which is relevant to the processing of the claim or which in any manner has a bearing on the claim has been withheld or not disclosed.

(c) If I have given/made any false or fraudulent statement/information, or suppressed or concealed or in any manner failed to disclose material information, the policy shall be void and that I shall not be entitled to all/any rights to recover thereunder in respect of any or all claims, past, present or future.

(d) The receipt of this claim form/other supporting/related documents does not constitute or be deemed to constitute an agreement by the Company of the claim and the Company reserves the right to process or reject or require further/additional information in respect of the claim.

In case of Maternity Benefits Extension

I hereby declare that at the time of delivery covered by this claim, I did not have more than two living children. I hereby warrant the truth of foregoing particulars in every respect and I agree that if I have made or shall make any false or untrue statements, suppression or concealment, my right to claim reimbursement of the said expenses shall be absolutely forfeited notwithstanding any other action that the Company may take against me under the rules. I further declare that in respect of the above treatment, no benefits are admissible under any other Medical Scheme or insurance.

In case of Reimbursement of Cost of Health Check-Up Extension

I confirm that no claim has been made by my family members or me for the past 4 policy periods nor any claim is proposed to be lodged for the said period.

Place:

Date: **Signature of Insured Employee**

Important:

Since it is a pre-requisite for admission of claims under the policy that the Hospital / Nursing Home / Clinic where the Insured Person was admitted, is registered with Local Authorities, it is necessary for the claimant to ensure that the Hospital / Nursing Home / Clinic indicates the same on the Bill-cum-Receipt issued by them.

(To be filled in by the Employer/Insured)

Was the injured person in respect of whom claims being made absent from work? If so, please furnish the details of such absence	Yes/No

I / We hereby declare that the particulars made by the injured person in the claim from are true to the best of our knowledge and belief.

Place :

Date :

Signature of the Insured

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