ICICI LOMBARD GENERAL INSURANCE COMPANY LIMITED.

Regd. Office : ICICI Bank Towers, Bandra Kurla Complex, Mumbai – 400 051
Tel: (+91 22) 653 1414 Fax : (+91 22) 653 1657

# CLAIM FORM FOR CRITICAL CARE POLICY

GUIDELINES FOR COMPLETION OF THE FORM

1. Please answer all questions fully and correctly. Where any question does not apply, please mention clearly that the same is not applicable.

2. The completion and return of this form to the Company should not be delayed if any of the particulars required cannot be immediately given. They may be forwarded to the Company afterwards, as soon as possible.

3. The Policy shall become voidable at the option of the Insurer, in the event of any untrue or incorrect statement, misrepresentation, non-description or on non-disclosure in any material particularly in the claim form/personal statement, declaration and connected documents, or any material information having been withheld by the insured or any one acting on his behalf.

4. Kindly contact the Company's Offices or Agents for any doubts or clarifications on the claim form.

5. On receipt of the claim form, communication for claim documents would be sent depending upon the nature of insured event for which the claim has been lodged

NOTE

- The issue of this form is not to be construed as an Admission of Liability.
- Please send the claim form to:
  **Secure Mind Claims**
  **ICICI Lombard GIC Ltd, Zenith House, 2nd Floor, Keshavrao Khadye Marg, Mahalaxmi, Mumbai – 400 034**

## DETAILS OF THE POLICY

Policy No: _____

Period of Insurance : _____

## DETAILS OF INSURED

1. Name of the Insured : _____

2. Address of the Insured: _____
_____
_____

3. Date of Birth: _____

4. Whether Self Employed/ Salaried :_____

## CLAIM DETAILS

5. Nature of Insured Event: **(Please tick the relevant box)**

☐ (i) Death due to accident

Date of Accident _____
Brief Narration of the Cause of accident _____
Place of accident _____

☐ (ii) Permanent Total Disability due to Accident

Date of Accident _____
Brief Narration of the Cause of accident _____
Place of accident _____

☐ (iii) Major Medical Illness or Procedure :

a) Date of Diagnosis of Major Medical Illness or undergoing of surgery _____

b) Please select the type of Major Medical Illness suffered or surgery undergone from the list below

- ❑ Cancer
- ❑ End Stage Renal Failure
- ❑ Major Organ Transplant
- ❑ Stroke
- ❑ Paralysis
- ❑ Heart Valve Replacement Surgery
- ❑ Multiple Sclerosis
- ❑ Coronary Artery By Pass Graft Surgery
- ❑ Heart Attack (Myocardial Infraction)

Name of the treating doctor: _____
Contact details of the treating doctor: _____
_____

*Declaration*

I hereby agree, affirm and declare that :

(a) The statements/information given/stated by me 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 there under 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 to pay the claim and the Company reserves the right to process or reject or call for further/additional information in respect of the claim.

(e) As per the policy terms and conditions, the Company reserves its right to have the Insured examined by any doctor at any hospital / diagnostic centre or clinic appointed by it for verification of diagnosis/illness/ailment/procedure or disablement

I hereby declare that the particulars made by the insured person/claimant in the claim form are true to the best of my/our knowledge and belief. I also authorize ICICI Lombard Gen Insurance Company to seek any medical information, document/report from any Medical Practitioner/Hospital or any other body/organization who has at any time attended/treated the insured for whom the claim is being lodged.

Name of Claimant:

Address for correspondence:

Phone No: **Signature of Claimant**

**Date:** _____ **Place:** _____