ICICI Pru ClaimCare

24x7 CustomerHelpline No: 1860 266 7766

ICICI PRUDENTIAL LIFE INSURANCE

CLAIM FORM - PART A
TO BE FILLED IN BY THE INSURED
The issue of this Form is not to be taken as an admission of liability

1S CLAIMANT STATEMENT FORM (HEALTH CLAIMS)

- The Claimant statement form must be filled by the beneficiary under the policy or by the legally entitled person
- Early submission of this form along with the required documents listed below, will enable us to process your claim faster
- To initiate claim processing please submit all documents
- Send all required documents to "Claim Cell" address mentioned on last page of this form

DOCUMENTS TO BE SUBMITTED#		
Fixed Benefit Hospitalization Claims Application for ICICI Pru Hospital Care/ ICICI Pru Hospital Care II	**Indemnity Hospitalization Claim Applicable for ICICI Pru MediAssure /ICICI Pru Health Saver**	**Critical Illness Claim/*Terminal Illness Claim/ MSAR/ ADBR Applicable for ICICI Pru Crisis Cover/ Rider Claim/ *Heart and Cancer Protect**
1. Copy of Discharge Card 2. Cancelled cheque for processing electronic payment 3. Fixed Benefit Hospitalization Claims Applicable for ICICI Pru Hospital Care/ ICICI Pru Hospital Care II	1. Original Discharge Card 2. Original Hospital / Pharmacy Bills & Payment Receipts and Records 3. Original Investigation Reports & Bills 4. Cancelled cheque for processing electronic payment 5. Indemnity Hospitalization Claim Applicable for ICICI Pru Medi Assure/ ICICI Pru Health Saver for	1. Original Policy Certificate 2. Definition Fulfillment Document 3. Cancelled Cheque for processing electronic payment 4*. All reports, including but not limited to all medical reports, case histories, investigation, reports, treatment papers, discharge summaries 5*. A precise diagnosis of the treatment for which a claim is made

#Additional medical records may be called on case to case basis

POLICY DETAILS:

8 Digit Policy Number(s):

(Please mention all policy numbers with ICICI Prudential Life Insurance Co)

DETAILS OF CLAIMANT:

a) Name:

b) Address:

City:

State: Pin Code:

c) Contact details: Mobile number Alternate Mobile number

Convenient time to call Phone number

d) Date of birth: D D M M Y Y Y Y Email ID:

e) Relationship with the Life Assured: f) Pan No:

1. Do you want to register the above address for future correspondence? ☐ Yes ☐ No
(If Yes, please submit current address proof)

2. ARE YOU A POLITICALLY EXPOSED PERSON (CLAIMANT)? ☐ Yes ☐ No

Politically Exposed Persons (PEPs) are individuals who are or have been entrusted with prominent public functions in a foreign country, example, Heads of State or of Governments, senior politicians, senior government / judicial / military officials, senior executives of state owned corporations, important political party officials, etc., including their family members and close relatives. Default value will be taken as NO, if left blank.

DETAILS OF INSURED PERSON HOSPITALIZED:

a) Name:

b) Gender: ☐ Male ☐ Female c) Age: Years Months d) Date of birth: D D M M Y Y Y Y

e) Relationship to Primary insured: ☐ Self ☐ Spouse ☐ Child ☐ Father ☐ Mother ☐ Other (Please Specify)

f) Occupation: ☐ Service ☐ Self Employed ☐ Homemake ☐ Student ☐ Retired ☐ Other (Please Specify)

g) Address: (if different from above)

City:

State: Pin Code: Phone No:

Phone No: Email ID:

DETAILS OF HOSPITALIZATION:

a) Name of Hospital where Admitted:

b) Room Category occupied: ☐ Day care ☐ Single occupancy ☐ Twin sharing ☐ 3 or more beds per room

c) Hospitalization due to: ☐ Injury ☐ Illness ☐ Maternity

d) Date of Injury / Date Disease first detected /Date of Delivery: D D M M Y Y Y Y

e) Date of Admission: D D M M Y Y Y Y f) Time: H H M M g) Date of Discharge: D D M M Y Y Y Y h) Time: H H M M

i) If Injury give cause: ☐ Self inflicted ☐ Road Traffic Accident ☐ Substance Abuse/Alcohol Consumption

I) If Medico legal: ☐ Yes ☐ No II) Reported to police ☐ Yes ☐ No III) MLC Report & Police FIR attached: ☐ Yes ☐ No

j) System of Medicine:

COMP/DOC/Mar/2019/293/2235

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 (code): ₹

Total: ₹

vii. Pre-hospitalization period: Days viii. Post-hospitalization period: Days

b) Claim for Domiciliary Hospitalization: ☐ Yes ☐ No (If yes, provide details in annexure)

c) Details of Lump sum / cash benefit claimed:

i. Hospital Daily Cash: ₹ ii. Surgical Cash: ₹

iii. Critical Illness Benefit: ₹ iv. Convalescence: ₹

v. Pre/Post hospitalization Lump sum benefit: ₹ vi. Others (code): ₹

Total: ₹

Claim Documents Submitted- Check List:

☐ Claim Form Duly signed ☐ Copy of the claim intimation, if any ☐ Hospital Main Bill ☐ Hospital Break-up Bill

☐ Hospital Bill Payment Receipt ☐ Hospital Discharge Summary ☐ Pharmacy Bill ☐ Operation Theatre Notes

☐ ECG ☐ Doctor's request for investigation ☐ Investigation Reports (Including CT / MRI / USG / HPE)

☐ Doctor's Prescriptions ☐ Others

DETAILS OF BILLS ENCLOSED:

Sl No.	Bill No.	Date	Issued by	Towards	Ammount (₹)
1		D D M M Y Y Y Y		Hospital Main Bill	
2		D D M M Y Y Y Y		Pre-hospitalization Bills: Nos	
3		D D M M Y Y Y Y		Post-hospitalization Bills: Nos	
4		D D M M Y Y Y Y		Pharmacy Bills	
5		D D M M Y Y Y Y			
6		D D M M Y Y Y Y			
7		D D M M Y Y Y Y			
8		D D M M Y Y Y Y			
9		D D M M Y Y Y Y			
10		D D M M Y Y Y Y			

HEALTH/ HABIT DETAILS OF LIFE ASSURED:

Nature of Illness / Habit (Please select ✓/×)	Duration (since when)	If Yes, Treatment/Quantity Details
☐ Hypertension ☐ Diabetes		
☐ Heart disease ☐ Liver disease ☐ Kidney disease ☐ Cancer		
☐ Any other ailments / disorder/ surgery/ hospitalisation in last 5 Yrs		
☐ Smoking ☐ Alcohol ☐ Tobacco ☐ Drugs		

EMPLOYMENT DETAILS:

a) Employer's/ Business name:

b) Address: Designation at work place/ business:

Telephone with STD code:

Email id:

City Pin Code State

PLEASE GIVE THE DETAILS OF THE MEDICAL / SICK LEAVE TAKEN IN LAST 5 YEARS.

Dates From	Dates To	Reasons as per Medical Certificate / Leave Application	Employer Insurance Availed Yes / No

PARTICULARS OF OTHER HEALTH INSURANCE / MEDICLAIM POLICIES HELD BY THE LIFE ASSURED

Name of the Company / TPA	Policy No. Date	Risk Commencement	Sum Assured	Claim Raised Yes/No	Illness/ Disease	Date of Illness

CLAIM BENEFIT PAYOUT OPTION (applicable for Terminal illness claim for IProtect Smart policy only)*

*Benefit option selected at policy inception cannot be changed, only payout method can be changed at claims stage.
*Change in payout method at claims stage is not applicable if benefit option "Lump sum "is chosen at policy inception.
#Interest rate used for deriving present value of future payouts is 4% p.a.

Income Option	Increasing Income Option	Lump sum and Income Option
☐ As opted at policy inception	☐ As opted at policy inception	☐ As opted at policy inception
☐ Advance 1st year's income as lump sum and remaining in monthly instalments	☐ Advance 1st year's income as lump sum and remaining in monthly instalments	☐ Lump sum (Present value of future payouts)#
☐ Lump sum (Present value of future payouts)#	☐ Lump sum (Present value of future payouts)#	

ELECTRONIC PAYOUT OPTION (Direct transfer of funds to your Bank Account) Please submit cancelled cheque / cheque copy along with this form.)

Name of Account Holder
(as mentioned in Bank Account)

Bank Name

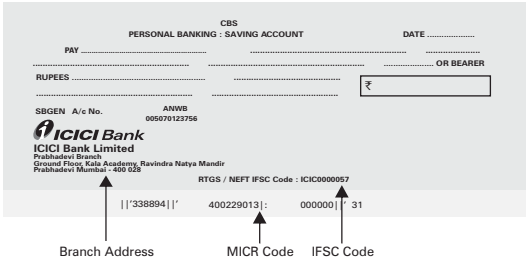
Branch Name & Address

CBS Account No.

IFSC Code

MICR Code

9 digit code as appearing on the Cheque copy issued by bank.
Please attach a copy of cancelled Cheque for verifying MICR code.



Account Type ☐ Current Account ☐ Saving Account

The payout mode selected in this form would be used by the Company to make all payout(s) to the claimant. Payouts would be in accordance and subject to the terms and conditions of the policy. Further the Company reserves the right to use any alternative payout option including demand draft/payable at par cheque inspite of opting for electronic payout method. Responsibility of providing IFSC code lies with the customer. Please note that IFSC code for RTGS & IFSC code for NEFT may be different.
I will not hold ICICI Prudential Life Insurance Company Ltd. responsible in cases of non-credit to my bank account or if the transaction is delayed or not effected at all for reasons of incomplete/ incorrect information provided by me in this form.

×

Signature / Thumb impression of the Owner/ Proposer

Place: Date: D D M M Y Y Y Y

AUTHORIZATION / DECLARATION

To,
Claims Team,
ICICI Prudential Life Insurance Limited, Mumbai

Policy Number (s):

I, Mr. / Ms. / Mrs. (name),

(relation) of Mr. / Ms. / Mrs. (name of the Life Assured), do hereby declare that the above statements are true in each & every respect.

(I hereby declare that the information furnished in this claim form is true & 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 hereby give my consent to ICICI Prudential Life Insurance Co. Ltd. and its representatives to obtain information/ documents (including photocopies) from past and the present employer(s)/ Business Associates/ Medical Practitioners/Hospitals (Government/Private)/ Birth and Death Registrar/ Any life and non-life insurance company and Life Insurance Association's Medical Register.

I hereby request the relevant authorities to release to ICICI Prudential Life Insurance Co. Ltd. and its representatives any details regarding state of health, habits and occupation of the life assured within his/ her knowledge before or after the policy was issued and ICICI Prudential Life Insurance Co. Ltd. to release to any Life and non-life insurance company/ or life insurance Association's medical register, such details and provide the record of employment/business or other details as may be considered relevant.

Yours faithfully,

Mobile Number

Place:

×

Signature / Thumb impression of the Owner/ Proposer

Date: D D M M Y Y Y Y

Witness Authorization (Required where Owner/ Proposer has provided Thumb Impression / Signature in Vernacular Language)

Content of this form and its particulars has been explained by me in vernacular language to the Owner/ Proposer

Name of the Witness: Relation with Claimant

Mobile Number

Place:

×

Signature of the Witness

Date: D D M M Y Y Y Y

ICICI Pru ClaimCare

24x7 CustomerHelpline No: 1860 266 7766

ICICI PRUDENTIAL LIFE INSURANCE

CLAIM FORM - PART B
TO BE FILLED IN BY THE HOSPITAL
The issue of this Form is not to be taken as an admission of liability

DETAILS OF HOSPITAL

a) Name of the Hospital:

b) Hospital ID: c) Type of Hospital: ☐ Network ☐ Non Network (If non network fill section E)

d) Name of the treating doctor: e) Qualification:

f) Registration No. with State Code: Phone No:

DETAILS OF THE PATIENT ADMITTED

a) Name of the Patient: b) IP Registration Number:

c) Gender: ☐ Male ☐ Female d) Age: ☐☐ Years ☐☐ Months e) Date of birth: D D M M Y Y Y Y

f) Date of Admission: D D M M Y Y Y Y g) Time: H H M M h) Date of Discharge: D D M M Y Y Y Y i) Time: H H M M

j) Type of Admission: ☐ Emergency ☐ Planned ☐ Day care ☐ Maternity

k) If Maternity: i) Date of Delivery: D D M M Y Y Y Y ii. Gravida Status: ☐☐

l) Status at time of discharge: ☐ Discharge to home ☐ Discharge to another hospital ☐ Deceased m) Total claimed amount:

DETAILS OF AILMENT DIAGNOSED (PRIMARY)

a)	ICD10 Codes	Description	b)	ICD10 Codes	Description
i. Primary Diagnosis:			i. Procedure1:		
ii. Additional Diagnosis:			ii. Procedure2:		
iii. Co-morbidities:			iii. Procedure3:		
iv. Co-morbidities:			iv. Details of Procedure:		

c) Pre existing illness:

d) Pre-authorization obtained: ☐ Yes ☐ No e) Pre-authorization Number:

f) If authorization by network hospital not obtained, give reason:

g) Hospitalization due to Injury: ☐ Yes ☐ No

i. If Yes, give cause: ☐ Self-inflicted ☐ Road Traffic Accident ☐ Substance abuse / alcohol consumption

ii. If Injury due to Substance abuse / alcohol consumption, Test Conducted to establish this: ☐ Yes ☐ No (If Yes, attach reports)

iii. If Medico legal: ☐ Yes ☐ No iv) Reported to Police : ☐ Yes ☐ No v. FIR no.

vi. If not reported to police give reason:

CLAIM DOCUMENTS SUBMITTED - CHECK LIST

- ☐ Claim Form duly signed
- ☐ Original Pre-authorization request
- ☐ Copy of the Pre-authorization approval letter
- ☐ Copy of photo ID card of patient verified by hospital
- ☐ Hospital Discharge summary
- ☐ Operation Theatre notes
- ☐ Hospital main bill
- ☐ Hospital break-up bill
- ☐ Investigation reports
- ☐ CT/MR/USG/HPE investigation reports
- ☐ Dodor's reference slip for investigation
- ☐ ECG
- ☐ Pharmacy bills
- ☐ MLC report & Police FIR
- ☐ Original death summary from hospital where applicable
- ☐ Any other, please specify

DETAILS IN CASE OF NON NETWORK HOSPITAL (Only in case of non network)

a) Address of the Hospital:

City: State: Pin Code:

b) Phone No: c) Registration No. with State Code:

d) Hospital PAN: e) Number of Inpatient beds:

f) Facilities available in the hospital: i. OT: ☐ Yes ☐ No ii. ICU: ☐ Yes ☐ No

iii. Others:

DECLARATION BY THE HOSPITAL **(PLEASE READ VERY CAREFULLY)**

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 fad, our right to claim under this claim shall be forfeited.

Date: D D M M Y Y Y Y

Place:

Signature and Seal of the Hospital Authority:

FOR OFFICE USE ONLY (BRANCH OPERATIONS): **Date** D D M M Y Y Y Y

Life Assured /Nominee Name:
(Should match with name mentioned in policy certificate)

Claim Submitted By ☐ Life Assured ☐ Nominee ☐ Family Member ☐ Advisor ☐ Other

Original Documents Submitted for Health Saver / MediAssure Product ☐ Yes ☐ No

Phone Number of Person Submitting Claim:

Name of the Claims Assessor contacted **Phone No.**

Employee Name & Code **SPAARC Call ID:**

STAMP & TIME

ICICI Pru ClaimCare
Customer Care No: 1860 266 7766

ACKNOWLEDGMENT SLIP
(HEALTH CLAIMS)

ICICI PRUDENTIAL LIFE INSURANCE

Policy Number(s)

Name of Claimant

Branch Name & Code

Date D D M M Y Y Y Y **Employee Name & Code**

Documents submitted (Please select ✓/×)	Original	Photocopy
Policy Certificate		
Discharge Card		
Investigation Reports & Bills		
Hospital / Pharmacy Bills & Receipts		
ECS and Cancelled cheque for Payment		

STAMP & TIME

- At ICICI Prudential Life insurance Co. Ltd our endeavor is to ensure that customer receives communication within 15 days from receipt of all requisite documents
- The acknowledgment slip should not be construed as acceptance of claim. The Company reserves the right to call for additional documents/ requirements

CLAIM CONTACT POINTS

24x7 ClaimCare Cell:	**Email us:**	**SMS Service:**
Customer Care No: 1860 266 7766	lifeline@iciciprulife.com	ICLAIM<space>8 digit policy no. to 56767