Claim Number ________________________ (to be filled in by ICICI PRU officials)

Claim Statement Form (Health Claims)

Please submit this form along with the requirements mentioned below at the address given in page 2

In support of the claim, I enclose following documents (Please indicate by ticking in the Yes / No column)

Documents to be submitted	Hospitalisation			Critical Illness (CI)			Death		
	Required	Yes	No	Required	Yes	No	Required	Yes	No
Original Policy Certificate*	✓			✓			✓		
Attending Doctor's Certificate	✓			✓			✓		
Discharge Card / Discharge Summary	✓			✓			✓		
Admission Notes / Indoor Case Papers	✓			✓			✓		
Hospital / Pharmacy / Doctor Bills	✓			×			×		
All relevant investigation reports	✓			✓			✓		
Death Certificate issued by Local Authority	×			×			✓		
Post Mortem Report, FIR, Panchnama, MLC**	×			×			✓		

* In case of Hospitalization Product submit photocopy of policy certificate

** In case of accidental claim please submit FIR (First Information Report) & MLC (Medico Legal Certificate)

- Please provide any other relevant supporting document for faster processing of claim
- The company reserves the right to call for additional documents / requirements

1. Claim Details:

Policy Number (8 Digit Number): ☐☐☐☐☐☐☐☐

Claim Description: ________________________

In case of Death (Date & Place of Death): ________________________

2. Life Assured Details:

Name:	
Address of Insured:(Including State, City, Pincode)	Telephone with STD code:
	Mobile Number:
	E- mail:

3. Claimant Details: (In case the Life Assured & claimant are different):

Name:	Relationship with the Life Assured:
Address of Insured:(Including State, City, Pincode)	Telephone with STD code:
	Mobile Number:
	E- mail:

4. Previous Health details of Life Assured:

Illness (Please tick the relevant box in the Yes / No column)	Yes	No	Duration (since when)	If Yes, Treatment Details
Hypertension				
Diabetes				
Heart disease				
Kidney disease				
Any other ailments / disorder				
Any previous hospitalization in last 2 years				
Availed sick leave for continuous 5 days (in last 2 years)				

5. Treatment / Diagnosis Details :

Nature of the Illness / Treatment:	
Date of Diagnosis (DD / MM / YYYY):	Exact Diagnosis of Illness:
Date of Admission (DD / MM / YYYY):	Date of Discharge (DD / MM / YYYY):
Symptoms that triggered the need to seek medical opinion for the illness:	
Duration of symptoms related to current illness:	

6. Details of the Doctor / Hospital for the current illness:

Name of Doctor:	Name of Hospital:
Address (Including State, City, Pincode)	Telephone with STD code:
	E- mail:

7. Details of the Family Doctor :

Name of Doctor:	Name of Hospital:
Address (Including State, City, Pincode)	Telephone with STD code:
	E- mail:

8. Particulars of other Life Insurance / Mediclaim policies held by the Life Assured:

Name of the Company / TPA	Policy No.	Risk Commencement Date	Sum Assured	Any Claim (Yes/No)	Cause of Claim	Status of Claim	Amount Claimed

I, ____________________________________ do hereby declare that the above statements are true in each & every respect.

Signature / Thumb impression of the Life Assured

Authorization / Declaration

To,
Health Claims Cell,
ICICI Prudential Life Insurance Limited, Mumbai

I, Mr. / Ms. ______________________________(name), ____________ (relation) of Mr. / Ms. ___________________________(name of the Life Assured) hereby give my consent to M/s ICICI Prudential Life Insurance Co. Ltd., and / or its representative to obtain (including photocopies) all the employment / medical / hospital records / other records / information pertaining to the treatment / occupation of Mr. / Ms. ________________.

Yours faithfully,

____
Signature of the Life Assured / Proposer/ Nominee
Name of the Life Assured / Proposer/ Nominee: Place Date:

Payout Options

Mode selected would be used by the company to make payout(s) to the proposer.
Payout would be in accordance and subject to the terms and conditions of the policy.

Full Name of the Account Holder:	
Payment Mode: ☐ NEFT ☐ Direct Credit (Select Banks)	MICR Code* (Mandatory for ECS):
Bank Name:	IFSC Code (Mandatory for NEFT):
Bank Account Number:	**Account Type:** ☐ Saving Account ☐ Current Account
Bank Address (Including State, City, Pincode):	Telephone with STD code:
	E- mail:

* 9 digit MICR code of the bank and branch appearing on the cheque issued by the bank. Submit a blank cancelled cheque along with the form. (Kindly ensure that the first four digits of MICR code that you fill in are all not zero.)

Disclaimer: 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 condition of the policy.

I declare and state that the company shall not be responsible for non credit of my bank account for any reason whatsoever or if the credit is delayed. I also understand and agree that the company reserves the right to use any alternative payout option including a demand draft payable at par or cheque, in spite of my opting for the electronic payout method. I undertake to provide IFSC code to the company. I understand that the IFSC code for RTGS and IFSC code for NEFT may be different.
I understand and agree that the submission of this form does not mean or amount to the acceptance of the claim by the company.
**To be filled in case a cancelled copy of your cheque is not attached:*

Bank Account No: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

I hereby take the sole responsibility for the correctness of my Bank Account number and other details of this form . I undertake that I will not hold the company responsible in any manner for any transactions affected by the company due to incorrect Bank A/C No . Or these details stated by me.

Signature of the Proposer

Location: Date:

Contact Details:

ICICI Prudential Life Insurance Company, Health Claim Cell; 1st Floor, Trade Point Kamala Mills Compound, Pandurang Budhkar Marg, Lower Parel, Mumbai 400013

To intimate your claim or seek any assistance sms: ICLAIM <space> <8 Digit Policy Number> and send to 56767