ICICI Pru ClaimCare

ICICI PRUDENTIAL LIFE INSURANCE

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**
- **Send all required documents to "Claim Cell" address mentioned on page 3 of this form**
- **To initiate claim processing please submit all documents**
- **Early submission of this form along with the required documents listed below, will enable us to process your claim faster**

claimantstatementform

DOCUMENTS TO BE SUBMITTED#		
Fixed Benefit Hospitalization Claims Applicable 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/ MSAR/ ADBR Applicable for ICICI Pru Crisis Cover / Rider Claim**
1. Copy of Discharge Card 2. Cancelled cheque for processing electronic payment	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	1. Original Policy Certificate 2. Definition Fulfillment Document 3. Cancelled cheque for processing electronic payment

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

1. POLICY DETAILS:

8 Digit Policy Number(s): _____ _____ _____ _____

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

2. CLAIMANT DETAILS:

Name: _____
First Name Middle Name Surname

Relationship with the Life Assured: _____ Date of Birth: DD/MM/YYYY

Address: _____ Telephone with STD code: _____

_____ Mobile Number: _____

City _____ Pin Code _____ State _____ Email ID: _____

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

2 b. 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.

3. LIFE ASSURED DETAILS:

Name: _____
First Name Middle Name Surname

4. DETAILS OF HOSPITALIZATION:

Diagnosis/ Illness: _____

Duration of Illness: _____ Date of Admission: DD/MM/YYYY Date of Discharge: DD/MM/YYYY

Name of Hospital: _____

Address: _____ Telephone with STD code: _____

_____ Mobile Number: _____

City _____ Pin Code _____ State _____

Name & Address of Police Station where FIR was lodged **(Please submit copy of FIR)** _____

_____ FIR No: _____

City _____ Pin Code _____ State _____ Telephone with STD code: _____

5. TOTAL NUMBERS OF BILLS ENCLOSED _____ TOTAL CLAIMED AMOUNT _____

6. 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		

Claim documents to be dispatched to:
ICICI Prudential Life Insurance Company Limited, 1st Floor, C wing, Office No. 115, 116, 117, BSEL Tech Park , Opp. Vashi Station, Sector 30 Vashi, Navi Mumbai - 400706.

Comp/doc/Nov/2011/609

7. EMPLOYMENT DETAILS:

Employer's/ Business name: _____

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

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

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

9. 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 _____

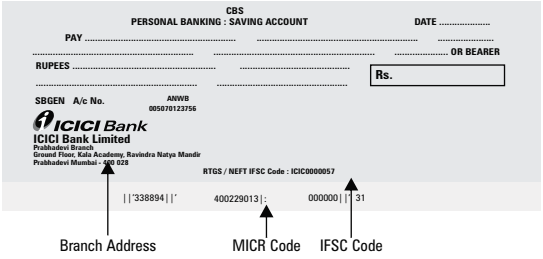
CBS Account No. | | | | | | | | | | | | | | | | | | | |

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: DD/MM/YYYY

FOR OFFICE USE ONLY (BRANCH OPERATIONS):

STAMP & TIME

☐ **ER** **Request submitted by** ☐ **S** ☐ **CR** ☐ **CS** **Date** DD/MM/YYYY

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:** _____

Claim documents to be dispatched to:
ICICI Prudential Life Insurance Company Limited, 1st Floor, C wing, Office No. 115, 116, 117, BSEL Tech Park , Opp. Vashi Station, Sector 30 Vashi, Navi Mumbai - 400706.

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 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: _____ DD/MM/YYYY _____

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: _____ DD/MM/YYYY _____

ICICI Pru ClaimCare

ACKNOWLEDGMENT SLIP (HEALTH CLAIMS)

ICICI PRUDENTIAL LIFE INSURANCE

Policy Number(s) _____ _____ _____ _____

Name of Claimant _____

Branch Name & Code _____

Date _____ DD/MM/YYYY _____ **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

- 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

Claim Cell:	**24x7 ClaimCare Cell:**	**Email us:**	**SMS Service:**
ICICI Prudential Life Insurance Co. Ltd. 1st Floor, C wing, Office No. 115, 116, 117, BSEL Tech Park , Opp. Vashi Station, Sector 30 Vashi, Navi Mumbai - 400706.	Customer Care No: 1860 266 7766 Call Center timings: 10.00 A.M. to 7.00 P.M. Monday to Saturday (except national holidays)	lifeline@iciciprulife.com	ICLAIM<space>8 digit policy no. to 56767