

Customer Helpline No.: 1860 266 7766



Critical Illness Claim/ MSAR/ ADBR

CLAIMANT STATEMENT FORM (HEALTH CLAIMS)

DOCUMENTS TO BE SUBMITTED#

Indemnity Hospitalization ClaimApplicable for

- 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

Fixed Benefit Hospitalization Claims Applicable for

Send all required documents to "Claim Cell" address mentioned on page 3 of this form

Any other ailments / disorder/ surgery/ hospitalisation in last 5 yrs

Tobacco

Drugs

Smoking

Alcohol

| ICICI Pru Hospital Care / ICICI Pru Hospital Care II | ICICI Pru MediAssure /ICICI Pru Health Saver | Applicable for ICICI Pru Crisis Cover / Rider Claim | | | | | |
|---|--|--|--|--|--|--|--|
| Copy of Discharge Card Electronic Payout Mandate(EPM) & Cancelled cheque in case Electronic Payout option opted | Original Discharge Card Original Hospital / Pharmacy Bills & Payment Receipts and Records Original Investigation Reports & Bills Electronic Payout Mandate(EPM) & Cancelled cheque in case Electronic Payout option opted | Original Policy Certificate Definition Fulfillment Document Electronic Payout Mandate(EPM) & Cancelled cheque in case Electronic Payout option opted | | | | | |
| #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 In | suranceCo) | | | | | | |
| 2. CLAIMANT DETAILS: | | | | | | | |
| Name: | | | | | | | |
| | Middle Name | | | | | | |
| Relationship with the Life Assured: | Date of Birth: | DD/MM/YYYY | | | | | |
| Address: | Telephone with S | TD code: | | | | | |
| | Mobile Number: | | | | | | |
| City Pin Code | State Email ID: | | | | | | |
| of State or of Governments, senior politicians, ser political party officials, etc., including their family r 3. LIFE ASSURED DETAILS: | who are or have been entrusted with prominent publior government / judicial / military officials, senior ex nembers and close relatives. Default value will be tak Middle Name | ecutives of state owned corporations, important en as NO, if left blank. | | | | | |
| 4. DETAILS OF HOSPITALIZATION: | | | | | | | |
| Diagnosis/ Illness: | | | | | | | |
| Duration of Illness: | | Date of Discharge: DD/MM/YYYY | | | | | |
| Name of Hospital: | | | | | | | |
| • | | | | | | | |
| | ielephone with 5 i | D code: | | | | | |
| | | D code: | | | | | |
| City Pin Code | Mobile Number: | D code: | | | | | |
| | State Mobile Number: | | | | | | |
| Name & Address of Police Station where FIR was | State Mobile Number: Stodged (Please submit copy of FIR) | | | | | | |
| Name & Address of Police Station where FIR was | State Slodged (Please submit copy of FIR) FIR No: | | | | | | |
| Name & Address of Police Station where FIR was | State Mobile Number: Stodged (Please submit copy of FIR) | | | | | | |
| Name & Address of Police Station where FIR was | State Slodged (Please submit copy of FIR) FIR No: | | | | | | |
| Name & Address of Police Station where FIR was City Pin Code | State Slodged (Please submit copy of FIR) FIR No: | | | | | | |
| Name & Address of Police Station where FIR was City Pin Code 5. HEALTH/ HABIT DETAILS OF LIFE ASSURED: Nature of Illness / Habit (Please select \(\sigma / \xi) \) Hypertension Diabetes | State State Slodged (Please submit copy of FIR) FIR No: State Telephone with STD |) code: | | | | | |

| 6. EMPLOYMEN | IT DETAILS: | | | | | | | | |
|---|--|---------------------------------------|---|----------------------|---|-------------------------------------|-----------------------|-------------|--|
| Employer's/ Bu | usiness name: | | | | | | | | |
| Address: | nployer's/ Business name: Idress: Designation at work place/ business: Telephone with STD code: | | | | | | | | |
| | | | | | | | | | |
| | | Email id: | | | | | | | |
| City | Pin Cod | е | State | | | | | | |
| Please give the | details of the me | dical / sick lea | ve taken in last 5 years | S. | | | | | |
| D |)ates | Reasons a | s per Medical Certifica | te / Leave Annlica | tion Em | ployer Inst | ırance Availed | | |
| From | То | licasolis a | is per ivieurcai cerunica | ite / Leave Applica | | Yes | / No | | |
| | | | | | | | | | |
| | | | | | | | | | |
| | ' | | | | ! | | | | |
| 7. PARTICULAR | S OF OTHER HEA | LTH INSURAN | CE / MEDICLAIM POLIC | CIES HELD BY THE | LIFE ASSURED | | | | |
| Name of t Company / | P0 | icy No. | Risk Commencement Date | Sum Assure | d Claim R Yes/ | | Illness/ Dis | ease | |
| | | | Date | | | | | | |
| | | | | | | | | | |
| | | | | | | | | | |
| 8. ELECTRONIC I | PAYOUT OPTION (I |)irect transfer | of funds to your Bank A | ccount) Please suhi | mit cancelled cheau | e / chemie | copy along with | this form | |
| Name of Accoun | nt Holder | | | , | • | - | | | |
| (as mentioned in Bank A Bank Name | • | | | | | | | | |
| | | | | | | | | | |
| CBS Account No | ······································ | | | | | CBS BANKING : SAVING A | CCOUNT DATE | | |
| IFSC Code | | | | | RUPEES | | Rs. | | |
| i | | | | | SBGEN A/c No. ANWE 005070123 PICICI Bank Limited Prabhadevi Branch | | | | |
| MICR Code | | II I I DI | | Y : MIOD I | Prabhadevi Branch Ground Floor, Kala Academy, Ravindra Na Prabhadevi Mumbai - 400 028 | tya Mandir RTGS / NEFT IFSC Code | e : ICIC0000057 | | |
| Account Type | Current Accou | · | och a copy of cancelled Cheque for ving Account | remying ivlick code. | | † | 000000 | | |
| | <u> </u> | | | | Branch Address | | e IFSC Code | | |
| subject to the to draft/payable at p | erms and condition | ns of the policy of opting for ele | used by the Company to y. Further the Company ectronic payout method. If ferent. | reserves the right | to use any alternat | ive payout | option including | g demand | |
| | | • | any Ltd. responsible in c | ases of non-credit t | to my bank account | or if the tra | nsaction is delay | ed or not | |
| | | | formation provided by me | | o my bank account | or ii tiio tia | nodotion to dold) | 700 01 1101 | |
| | | | | | | | | | |
| | | | | | | | | | |
| × | | | | | | | | | |
| Signature / T | humb impression | of the Owner/ | Proposer | Place: | | Date: | DD/MM/YYY | Y | |
| . | • | · | • | | | | | | |
| FOR OFFICE U | JSE ONLY (BRANCI | I OPERATIONS | i): | | | | Date _{DD/MN} | 1/YYYY | |
| | | | | | | | | | |
| | /Nominee Name: | | | | | | | | |
| | name mentioned in policy co | | | | _ | | | | |
| Claim Submit | tted By Life | Assured \(\bigcap \) | Iominee | nber Advisor | Other | | | OTABAC | |
| Original Docu | ıments Submitted | for Health Sa | ver / MediAssure Produ | ıct Yes | ☐ No | | | STAMP & | |
| Phone Number | er of Person Subm | itting Claim: ַ | | | | | | TIME | |
| Name of the | Claims Assessor o | ontacted | | Dhon | - N- | | | | |
| | | | | | | | | | |
| Employee Na | me & Code | | SPAARC (| Call ID: | | | | | |

AUTHORIZATION / DECLARATION Claims Team, ICICI Prudential Life Insurance Limited, Mumbai Policy Number (s): I, Mr. / Ms. / Mrs. (name of the Life Assured), do hereby declare (relation) of Mr. / Ms. / Mrs. 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: X 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 **ACKNOWLEDGMENT SLIP ClaimCare** FICICI PRUDENTIAL (HEALTH CLAIMS) Customer Helpline No.: 1860 266 7766 Policy Number(s) Name of Claimant Branch Name & Code Employee Name & Code Original Documents submitted (Please select √/x) **Photocopy Policy Certificate** Discharge Card Investigation Reports & Bills Hospital / Pharmacy Bills & Receipts ECS and Cancelled cheque for Payment



Claim Cell:

ICICI Prudential Life Insurance Co. Ltd., 9th Floor, B wing, Office No. 906, BSEL Tech Park, Opp. Vashi Station, Sector 30, Vashi, Navi Mumbai – 400706.



1860 266 7766

24x7 Customer Helpline No.:



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.

Email us:

lifeline@iciciprulife.com



SMS Service:

ICLAIM<space>8 digit policy no. to 56767