PARAMOUNT HEALTH SERVICES & INSURANCE TPA PRIVATE LIMITED (IRDA License No. 006)

[formerly known as PARAMOUNT HEALTH SERVICES (TPA) PVT.LTD]

Plot no.A-442, Road No-28,M.I.D.0 Industrial Area, Wagale Estate, Ram Nagar, Vitthal Rukmani Mandir, Thane (W), Mumbai, Pin Code — 400 604

CLAIM ACKNOWLEDGMENT SHEET

Name of Insurer :		**PHS ID :**	
Insured Name :		**Employee No :**	
Patient Name :		**Mobile No :**	
Policy No :		**Phone (STD) :**	
Name of Corporate:			
Type of Claim (To be ticked) :	Main Hospitalisation / Pre-Post Hospitalisation / OPD Claim / Deficiency Retrieval / Critical Illness / Cash Benefit	**E-Mail ID of primary insured :**	

CLAIM DOCUMENT CHECK LIST

Sr. No	Description	Document Status(Y/N)	Remarks
1	IRDA Claim Form duly signed by the Insured & Hospital		
	Part-A: Duly signed by the insured with Claimed amount ,Mobile number & Email ID along with PHS ID		
	Part-B: Duly signed and stamped by hospital		
	Declaration form duly signed & stamped by the hospital in case treatment taken is under PPN/GIPSA hospitals.		
1.a	Policy Declaration Form duly signed by the Insured & Hospital hospitals.		
2	In case of No Intimation / Delay Intimation & Delay in submission of claim, a letter from insured is required stating reason for the same.		
3	Original Cancelled Cheque Leaf of Employee/Proposer with the Name of the AccountHolder Printed on the Cheque Leaf.		
4	ID Proof of Employee / Primary Insured- Any of one (Passport,Voter ID, Driving License, Or any Government Approved ID) . If Claim is above 1 lakh- PAN is mandatory with address Proof		
5	ID Proof of Patient- Any of one (Passport,Voter ID, Driving License, Or any Government Approved ID)		
6	Original detailed Discharge Summary as per IRDA Format / Day care summary from the hospital (in case of Day Care Treatment) / Death Summary (in Case of Death Claim)		
6.a	Copy of the Legal heir certificate (if the claim is for the death of the principle insured)		
6.b	Copy of Post Mortem Report & Death Certificate (In Accidental Death cases)		
7	Policy Copy (**if individual policy)**		
8	64VB Compliance Certificate (**If individual policy)**		
9	Original Final Hospital bill with cost wise breakup of each Item		
10	Original Payment Receipt of Main Hospital bill (both Deposit / Refund)		
10.a	Receipt Of Payments made at the Hospital by Credit Card : Please attach the Xerox Copy of the Credit Card Payment Slip as received from the Vendor		
11	Original copy of Implant Invoice along with Payment Receipts & Implant Labels / Stickers for Stents/ Mesh/ IOL		
12	Original bills, original Payment Receipts and investigation / Laboratory Reports		
13	Original medicine bills specifying Patient Name and date of purchase along with supporting Prescriptions.		
14	Original copy of First Consultation letter and subsequent Prescriptions.		
15	Hospital Registration certificate issued by Competent authority as per Indian nursing council Act 1947 (If hospital not falls in GIPSA/PPN)		
16	**OTHER DOCUMENTS**		
16.a	Original copy of Obstetric history (Gravida, Para, Living children, Abortions) from treating doctor. (Maternity Claim)		
16.b	Original Sonography Report in case of Maternity Claim		
16.c	Original A-Scan Report along with IOL Sticker and Tax paid invoice in case of Cataract Claim		
16.d	Copy of the First Information Report (FIR) from Police Department / Copy of the Medico-Legal Certificate (MLC) in case of Road Traffic Accident (RTA)		
16.e	A medical certificate from a doctor not less qualified than MD/MS confirming the diagnosis of critical illness along with the Investigation reports/Other related documents reflecting the critical illness diagnosis. (Critical Illness Cases)		
16.f	In case of claims where the insured has submitted documents to another insurance cofTPA, he needs to submit attested Photocopies of all the documents along with detailed claim settlement letter from the TPA and any unpaid bills and receipt for the same in originals.		

Claims Submitted by : Insured / Corporate / Agent / Broker / Insurer / Hospital

Claim Submitted by:		**Mobile No.**	
Date of Claim Submission:	DD /MM/YYYY HH:MM	**PHS Executive Name:**	
Claim Submitted at:	PHS - (Location) / Help Des!	**Signature:**	

Important Points to Remember:-

1. Please mark either **V** **or** x against respective check box
2. Date of File Received will be considered as next working day for Claim Files picked up at Help Desk
3. Claim Need to be Submitted within 7 Working Days from Date of Discharge from Hospital
4. The above list of documents is indicative. In case of any other document requirement as specified by the Insurance Company, our document recovery team will contact you on receipt of your claim documents by us
5. Please visit us at www.paramounttpa.com to check Online Claim Status or download Paramount Mobile App
6. Member is advised to keep photocopies of all the papers since Insurer requires all the above documents in original. Documents once submitted will not returned unless approved & agreed by Insurer
7. Corrections in any documents are not allowed, otherwise it will not be entertained during adjudication.

ICICI Lombard Health Care Claim Form - Hospitalisation

(Issuance of this form is not to be taken as an admission of liability)

Overview Health Claim Form - Hospitalization

Part A		To be filled	Requirement
A1	Self Declaration	By insured/ insured relatives	To track the policy and other details of the insured
A2	Self Declaration		
A3	Available in Policy Copy/ Employee details		
A4	Available in Policy Copy		
A5	Available in Discharge Summary		
A6	Self Declaration		
A7	Self Declaration		
A8	Available in Hospital Bills/ Self Declaration		
A9	Available in Hospital Bills		
A10	Checklist		
A11, Page end	Self declaration		
	Part B		
B1	Hospital Details	To be filled by Hospital/ Treating doctor	To track the hospital details and the treatment details related to the patient admission
B2	Doctor Details		
B3	Patient details		
B4	Treatment / Procedure Details		
B5	Required only for Retail/ Individual customers		
Page end	Hospital declaration		
	Part C		
C1	Patient's Name	To be filled by Insured	For Electronic fund transfer to the bank account
C2	Policy Number		
C3	Card No./UHID No.		
C4	Group/ Company name		
C5	Claim number (if allotted)		
C6	Mobile/ Contact no.		
C7	Provide any 1 document of proposer		
C8	As per bank pass book		
Page end	Account holder's signature		
C-KYC No.	**Part D (Only for Retail/ Individual customers if claiming >₹ 1 lakh)**		
Yes	Please provide, if Central KYC (C-KYC) no. available:	To be filled by Insured	As per IRDA, C-KYC is mandate for claims greater than ₹ 1 lakh
	_ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _		
No	Please fill the C-KYC form		

Documents Submitted

S.No.	Document	Yes	No	Type of document
1.	**Claim form duly filled**	Y	N	Original
2.	**Discharge Summary/ Daycare Summary**	Y	N	Original
3.	**Final Hospital Bill**	Y	N	Original
4.	**Payment Receipts**	Y	N	Original
5.	**Investigation Reports**	Y	N	Original
6.	**Pharmacy Bills**	Y	N	Original
7.	**Implant Sticker/ Invoice**	Y	N	Original
8.	**Doctor Prescriptions**	Y	N	Photocopy
9.	**Consultation Paper**	Y	N	Photocopy
10.	**Age Proof**	Y	N	Photocopy
11.	**Indoor Case Paper**	Y	N	Photocopy
12.	**EFT (Copy of cancelled cheque/ self attested ID poof/ Bank attested copy of passbook with IFSC code**	Y	N	Photocopy
13.	**Part D - CKYC FORM (Only for Retail/ Individual customers if claiming >₹ 1 lakh)**	Y	N	Original

Mailing Address: ICICI Lombard Healthcare, ICICI Bank Tower, Plot No. 12, Financial District, Nanakram Guda, Gachibowli, Hyderabad-500032
Registered Office Address: ICICI Lombard House, 414, Veer Savarkar Marg, Near Siddhi Vinayak Temple, Prabhadevi, Mumbai 400 025.
Visit us at: www.icicilombard.com. • **E-Mail us at:** ihealthcare@icicilombard.com. • **Toll Free Number:** 1800 2666. • **Toll Free Fax Number:** 1800-209-8880
IRDA Registration No. 115

ICICI Lombard Health Care Claim Form - Hospitalisation

ICICI Lombard Nibhaye Vaade

ICICI Lombard Health Care

(Issuance of this form is not to be taken as an admission of liability)

ALL CLAIM SETTLEMENTS SHOULD BE MADE THROUGH NEFT (AS PER IRDA CIRCULAR), PLEASE PROVIDE YOUR BANK ACCOUNT DETAILS. REFER TO PART C.

Do You Know

- ★ Non-submission of original bills and receipts is the main reason for delay in claim settlements. Please provide the originals & mandatory documents
- ★ To receive update on your claim status, provide your mobile no. & E-mail ID
- ★ You can track your claim status at: www.icicilombard.com→Claims→Health Claims→Services→Track your claims

Part - A (To be filled by Insured)

TO BE FILLED IN CAPITAL LETTERS ONLY

A1. Type of Claim : Main Hospitalisation Expenses ☐ Pre & Post Hospitalisation Expenses ☐ Cashless Obtained: Yes ☐ No ☐

A2. Details of the Insured person in respect of whom claim is made: (patient details)

Name of the Patient: ☐ F I R S T ☐ M I D D L E ☐ L A S T

Card No./ UHID of the Patient:

Gender: Male ☐ Female ☐ Date of Birth: D D / M M / Y Y Y Y Completed age: Years ☐☐ Months ☐☐

Occupation: Service ☐ Self Employed ☐ Homemaker ☐ Student ☐ Retired ☐ Other ☐ (Please specify)__________

Are you previously covered by any other Mediclaim/ Health Insurance: Yes ☐ No ☐. If yes, Company name: __________

Current residential address:

City:

State: Pin code:

Mobile no. Landline no.

E-mail:

A3. For **Group/ Corporate** Policy	For **Individual/ Retail** Policy (**Mandatory*)
Member ID No./ Employee ID (Client ID):	*Claim Intimation Service Request no.:
	Is this a renewal policy: Yes ☐ No ☐
Group/ Company name:	If Yes, kindly mention your previous policy no.:

A4. Name of the Proposer*:

Relationship with Proposer*: (*Policy Holder. For Retail policy, Proposer name required. For Corporate policy, provide Employee name)

Current Policy No.: Card No./ UHID:

A5. Nature of disease/ illness contracted or injury suffered for which Insured was hospitalized (Diagnosis): __________

Name of hospital where admitted:

Room category occupied: Day care ☐ Single occupancy ☐ Twin sharing ☐ 3 or more beds per room ☐ Others __________

Date of Admission: D D / M M / Y Y Y Y Time: H H : M M Date of Discharge: D D / M M / Y Y Y Y Time: H H : M M

Date of injury sustained or disease/ Illness first detected: D D / M M / Y Y Y Y

If Injury, give cause: Self inflicted ☐ Road traffic accident ☐ Substance abuse/ Alcohol consumption ☐ Others __________

If Medico legal: Yes ☐ No ☐ Reported to police: Yes ☐ No ☐ MLC Report & Police FIR attached: Yes ☐ No ☐ (If yes, attach report)

System of Medicine: __________

Is there any another claim in any of our policies towards the above incident? Yes ☐ No ☐. If yes, provide AL/Claim No. __________

A6. Are you covered under any Topup/Additional policy : Yes ☐ No ☐ If yes, provide policy no.__________

A7. Currently covered by any other Mediclaim/ Health Insurance: Y N Date of commencement of first Insurance without break: D D M M Y Y

Have you been hospitalized in the last 4 years since inception of contract: Y N Date: D D / M M / Y Y Y Y Dignosis: __________

Have you lodged any claim against this particular admission date/ attached bills with any other Insurance company: If yes, attach settlement letter,

Company name: __________ Policy No. __________ Sum Insured: ₹

A8. 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 __________:	₹
		Total:	₹
vii. Pre-hospitalization period	☐☐☐ Days	viii. Post-hospitalization period:	☐☐☐ Days

क्लेम फॉर्म हिन्दी के लिए कृपया हमारी वेबसाइट पर जाँच कीजिए : www.icicilombard.com

Claim documents to be dispatched to: ICICI Lombard Healthcare, ICICI Bank Tower, Plot No. 12, Financial District, Nanakram Guda, Gachibowli, Hyderabad-500032

b) Claim for

i. Domiciliary Hospitalization: Yes ☐ No ☐ (If yes, provide details in annexure)

ii. Day care: Yes ☐ No ☐

iii. Extended care/ Inpatient rehabilitation: Yes ☐ No ☐

c) Details of lump sum/ cash benefit claimed:

i. Hospital daily cash: ₹ ☐☐☐☐☐☐☐ ii. Maternity: ₹ ☐☐☐☐☐☐☐

iii. Critical illness/PA/Donor Expenses: ₹ ☐☐☐☐☐☐☐ iv. Convalescence: ₹ ☐☐☐☐☐☐☐

v. Pre/ Post hospitalization lump sum benefit: ₹ ☐☐☐☐☐☐☐ vi. Others: _____ ₹ ☐☐☐☐☐☐☐

A9. Details of the amount claimed

Bill heads (as applicable)	**Bill number**	**Bill date**	**Bills attached**	**Amount**
Room rent		D D M M Y Y	Y N	₹
Doctors consultation/ Visit charges		D D M M Y Y	Y N	₹
Investigation charges (Includes Radiology and Pathology reports)		D D M M Y Y	Y N	₹
Surgeon and Asst. surgeon charges		D D M M Y Y	Y N	₹
Anesthetist charges & Operation theatre charges		D D M M Y Y	Y N	₹
Equipment charges/ Procedure charges		D D M M Y Y	Y N	₹
Cost of implant (If any)		D D M M Y Y	Y N	₹
Medicine charges (Includes ward and OT medicines and consumables)		D D M M Y Y	Y N	₹
Pharmacy charges		D D M M Y Y	Y N	₹
Taxes/ Surcharges/ Service charge		D D M M Y Y	Y N	₹
Miscellaneous/ Other charges		D D M M Y Y	Y N	₹
Pre hospitalization bills (If any)		D D M M Y Y	Y N	₹
Post hospitalization bills (If any)		D D M M Y Y	Y N	₹
Discount provided by hospital (If any)		D D M M Y Y	Y N	₹
Total claimed amount (In ₹) (Total claimed amount should be equal to the amount in attached bill documents)				₹

MANDATORY: CENTRAL KYC (C-KYC) FORM REQUIRED ONLY FOR RETAIL/ INDIVIDUAL CUSTOMERS IF CLAIMING >₹ 1 LAKH

A10. In support of the above claim, I enclose following documents in original (Please indicate by ticking in the **Yes/ No** column below)

Type of Document(s) - *Mandatory	**Yes**	**No**	**Type of Document(s) - As Applicable**	**Yes**	**No**
1. Claim form duly filled and signed*	Y	N	9. ICICI Lombard GIC Authorisation Letter	Y	N
2. Discharge summary*	Y	N	10. Implant name and invoice (if any) with implant sticker	Y	N
3. Hospital bills, Final/ main hospital bill and other bills (if any)*	Y	N	11. Indoor Case Papers	Y	N
4. Hospital payment receipt & other receipts supporting bills*	Y	N	12. Prescription papers/ Consultation papers	Y	N
5. Investigation reports* (Including ECG/ CT/ MRI/ USG/ HPE)	Y	N	13. Others (details) _____	Y	N
6. Medicine/ Pharmacy bills with doctors prescription*	Y	N	_____		
7. Age proof (Driving License/ PAN card/ Passport/ Aadhar copy)*	Y	N			
8. Part - C (For EFT/RTGS/ NEFT)*	Y		14. C-KYC FORM (Only for Retail/Individual customers, claiming >₹ 1 lakh)	Y	N

Please attach all the documents as per above serial number. Films like x-ray film, CT Scan film, MRI Scan film, etc. are not required. Provide reports only

A11.Please provide the reason for delay in submitting the documents
(Post 30 days from Date of Discharge)

Provide Details

Declaration by the Insured:

I hereby declare that the information furnished in this claim form is true and 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 also consent and authorize TPA/ insurance company, to seek necessary medical information/ documents from any hospital/ Medical Practitioner who has attended on the person against whom this claim is made. I hereby declare that I have included all the bills/ receipts for the purpose of this claim and that I will not be making any supplementary claim except the pre/ post-hospitalization claim, if any.

Date: D D / M M / Y Y Y Y Place: _____ Insured's Signature: _____

क्लेम फॉर्म हिन्दी के लिए कृपया हमारी वेबसाइट पर जाँच कीजिए : www.icicilombard.com

Claim documents to be dispatched to: ICICI Lombard Healthcare, ICICI Bank Tower, Plot No. 12, Financial District, Nanakram Guda, Gachibowli, Hyderabad-500032

Part - B (To be filled by Treating Doctor/ Hospital only)

B1. Details of the Hospital/ Nursing home in which treatment was taken

Name of the Hospital/ Nursing home:

Address:

City: State:

Pincode: Telephone no.: Mobile no.:

ROHINI ID: Type of Hospital: Network ☐ Non Network ☐. If Non Network, provide below details

Registration No. with State Code: _____ PAN: Number of Inpatient beds:

Facilities available in the hospital: OT: Y N ICU: Y N

B2. Details of the attending Medical Practitioner/ Doctor/ Treating Physician or Surgeon

Name:

Qualification: Registration no:

Telephone no.: Mobile no.:

B3. Details of the patient admitted

Name of the patient:

IP Registration no.: Gender: M F Age: Years Months Date of Birth: D D M M Y Y Y Y

Date of Admission: D D / M M / Y Y Y Y Time: H H : M M Date of Discharge: D D / M M / Y Y Y Y Time: H H : M M

Type of Admission: Emergency ☐ Planned ☐ Day Care ☐ Maternity ☐

Type of Treatment: Surgical Procedure ☐ Multiple Surgical Procedure ☐ Medical Treatment ☐

If Maternity, Date of Delivery: D D / M M / Y Y Y Y Gravida Status: G ☐ P ☐ A ☐ L ☐

Premature Baby: Yes ☐ No ☐

Status at time of discharge: Discharge to home ☐ Discharge to another hospital ☐ Deceased ☐

Total claimed amount: ₹

B4. Details of the procedure

Pre-authorization obtained: Yes ☐ No ☐ If yes, Pre-authorization No.:

If authorization by network hospital not obtained, give reason: _____

Date of injury sustained or disease/ illness first detected: D D / M M / Y Y Y Y

If Injury, give cause: Self inflicted ☐ Road traffic accident ☐ Substance abuse/Alcohol consumption ☐ Others _____

If Medico legal: Yes ☐ No ☐ Reported to police: Yes ☐ No ☐ MLC Report & Police FIR attached: Yes ☐ No ☐ (If yes, attach report)

FIR no._____ If not reported to Police, give reason: _____

If injury due to substance abuse/alcohol consumption, test conducted to establish this: Yes ☐ No ☐ (If yes, attach report)

B5. This section is mandatory only **if your health policy is not provided by your employer**

A) Diagnosis (ICD 10 Code primary & additional dignosis)	
i) Primary diagnosis (with ICD 10 code)	
ii) Additional diagnosis (with ICD 10 code)	
iii) Procedure diagnosis (with ICD 10 PCS code)	
B) Nature of surgery/ treatment given for present ailment	
C) Date of first consultation (Prior to hospitalization)	
D) Presenting complaints of the patient during admission	
E) Past medical history of the patient along with duration of illness (If yes, attach first & all past consultation paper)	
F) Was the patient under influence of alcohol during admission	
G) Whether the present treatment ailment is a complication of pre-existing disease ?	
i) If yes, please specify the disease (or) complication of any previous surgery done ?	
ii) If yes, please specify the details	
H) Whether the disease/ disorder is congenital in nature ?	
I) Number of in-patient beds in the hospital (including ICU)	

Declaration by the hospital

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

Registration No. of Hospital

(Rubber stamp of the hospital) Date: D D / M M / Y Y Y Y

_____

Doctor's Seal and Signature

As per the policy Terms and Conditions, the Company reserves its right to have the Insured examined by a doctor appointed by it for verification of diagnosis.

ICICI Lombard
Nibhaye Vaade

Part - C - NEFT Form
(For Direct Electronic Fund Transfer)

ALL CLAIM SETTLEMENTS SHOULD BE MADE THROUGH NEFT (AS PER IRDA CIRCULAR), PLEASE PROVIDE YOUR BANK ACCOUNT DETAILS.

C1. Patient's Name: (in respect of whom claim is made):

C2. Policy Number:

C3. Card No./ UHID No.

C4. Group/Company Name (for Group/Corporate policy holders):

C5. Claim Number (if allotted): **C6. Mobile/ Contact No.:**

C7. Email:

C8. As per IRDA Circular No.: IRDA/F&A/CIR/GLD/056/02/2014, Proposer's/ policy holder's bank account details are mandatory to process the claim through EFT.

Please provide ANY ONE of the below documents of proposer/ policy holder-

- ☐ Please provide a self-attested copy of a valid Identity proof of the Proposer/Policy holder (provide any of the mentioned documents in Proof of Identity under Part-D)
- ☐ Cancelled cheque copy
- ☐ Bank attested copy of Passbook with IFSC code

C9. Please provide the below details (all fields are compulsory)

- Proposer (policy holder)/ Employee name*(as per bank records):
- Proposer/ policy holder Bank account no.:
- Name of the bank:
- Branch name:
- Address of the bank:
- IFSC code no. of the bank: (should be same as per the provided cheque leaflet)
- PAN no. of Proposer:

***Proposer/ Policy holder is the person who has paid premium for the policy.**
For Retail policy, Name & Account details of Proposer required. For Corporate policy, Employee Name & Account details required.

Terms and Conditions for Payments through RTGS/ NEFT

1. The details provided by the Proposers/ policy holder in the Mandate Form shall be considered as final and ICICI Lombard General Insurance Company Ltd. shall not be responsible for cross verification of any of the details provided therein.
2. The RTGS/ NEFT facility shall be effective for the respective Proposer(s)/ policy holder within 15 days of the receipt of the Mandate Form by ICICI Lombard General Insurance Company Ltd. and/ or within such period as may be reasonably required by ICICI Lombard General Insurance Company Ltd. to activate the RTGS/ NEFT facility.
3. The Proposer/ policy holder agrees that under the RTGS/ NEFT facility, there may be a risk of non-payment in the Proposer/ policy holder Accounts No. on the day of the credit of payments due to change in the applicable regulations pertaining to RTGS/ NEFT facility or due to any other reasons without any fault/ inaction/ failure on part of ICICI Lombard General Insurance Company or any factor beyond the control of ICICI Lombard General Insurance Company Limited.
4. The Proposer/ policy holder agrees to indemnify, without delay or demur, ICICI Lombard General Insurance Company Ltd. and its agents and keep ICICI Lombard General Insurance Company Ltd. and its agent indemnified harmless at all times from and against any and all claims, damages, losses, costs, and expenses (including attorney's fees) which ICICI Lombard General Insurance Company Ltd. may suffer or incur, directly or indirectly, arising from or in connection with, amongst other things, either of the aforesaid reasons stated in above clauses.
5. ICICI Lombard General Insurance Company Ltd. May sub-contract and employ agents to carry out any of its obligations under the RTGS/ NEFT facility. The Proposer/ policy holder may discontinue or terminate the use of RTGS/ NEFT facility by giving a minimum of 15 days prior written notice to ICICI Lombard General Insurance Company Ltd. The notice of, such termination should be given to ICICI Lombard only at its corporate address and be addressed at ICICI Lombard GIC Ltd., ICICI Lombard House (Old Tata Press Building), 414, Veer Savarkar Marg, Near Siddhi Vinayak Temple, Prabhadevi, Mumbai - 400025.
6. A confirmation of the receipt of termination notice given by the Proposer/ policy holder will be acknowledged through a confirmation letter by ICICI Lombard General Insurance Company Ltd. In no case can the Proposer/ policy holder construe his termination notice as effective unless a confirmation has been provided by ICICI Lombard to the Proposer/ policy holder stating the date of receipt of such communication by the Proposer/ policy holder.
7. The Proposer/ policy holder agrees that transaction(s) through RTGS/ NEFT facility may attract inward RTGS/ NEFT charges, which if levied by the Proposer's/ policy holder's bank, shall be borne by the Proposer/ policy holder only.
8. ICICI Lombard has the absolute discretion to amend or supplement any Terms and Condition stated herein at any time and will endeavor to give prior notice of ten days for such changes wherever feasible for the Terms and Conditions to be applicable. By using the new services, or at the completion of such period, whichever is earlier, the Proposer/ policy holder shall be deemed to have accepted the changed Terms and Conditions.
9. Submission of documents or bank details or any other information does not in any way, shape or form, imply or express or suggest admission of liability by the company.
10. Notices under these Terms and Conditions may be given in writing by delivering them by hand or e-mail or on ICICI Lombard General Insurance Company Ltd. website www.icicilombard.com or by sending them by post to the last address of the Proposer/ policy holder.
11. These Terms and Conditions will be governed by the laws of India and any legal action or proceedings arising out of these Terms and Conditions shall be initiated in the courts or tribunals at Mumbai in India.
12. I/We further undertake to refund any excess amount whether demanded by ICICI Lombard General Insurance Company Ltd. or not, which has been credited in excess to my account at any time due to any reason within 7 days of such receipt of such communication from ICICI Lombard of such excess credit or such information of excess credit coming to the knowledge of the Proposer/ policy holder through any other source.
13. I/We agree that my/ our claim payment will be credited from the date ICICI Lombard General Insurance Company Ltd. gets confirmation from its bankers, This facility will continue unless it is revoked by any party and any issuance of relevant credit instruction from ICICI Lombard General Insurance Company Ltd. to its bankers will be valid till such instruction is complete irrespective of the fact that the notice period has expired provided such a credit request has been made by ICICI Lombard General Insurance Company Ltd. before the expiry of the notice period of the Proposer/ policy holder.

Account holder's Signature

ICICI Lombard
Nibhaye Vaade

Mailing Address: ICICI Lombard Healthcare, ICICI Bank Tower, Plot No. 12, Financial District, Nanakram Guda, Gachibowli, Hyderabad-500032
Registered Office Address: ICICI Lombard House, 414, Veer Savarkar Marg, Near Siddhi Vinayak Temple, Prabhadevi, Mumbai 400 025.
Visit us at: www.icicilombard.com. • **E-Mail us at:** ihealthcare@icicilombard.com. • **Toll Free Number:** 1800 2666.
• **Toll Free Fax Number:** 1800-209-8880 • IRDA Registration No. 115

Paramount Health
Your link to good health

POLICY DECLARATION FORM

Date:……

Name of the Hospital :……

Address:……

PATIENT NAME (BLOCK LETTERS):…… AGE/SEX :……

Mobile No of Patient:……

Date of Admission:…… Date of Discharge:……

Undertaking by the Patient regarding Heath Insurance Policy
(स्वास्थ्य बीमा पॉलिसी के संबंध में रोगी द्वारा शपथ-पत्र))

☐ I declare that I do not have any health insurance policy.
(मैं घोषणा (खुलासा) करता हूं कि मेरे पास कोई भी स्वास्थ्य बीमा पॉलिसी नहीं है।

Signature: …… (हस्ताक्षर)
Name of the Patient/Patient's attendant (मरीज का नाम)

☐ I declare that I have health insurance policy.
(मैं घोषणा (खुलासा) करता हूं कि मेरे पास एक स्वास्थ्य बीमा पॉलिसी है।

Signature: …… (हस्ताक्षर)
Name of the Patient/Patient's attendant (मरीज का नाम)

Based on patient undertaking hospital declare that patient: (रोगी के उपक्रम के आधार पर हम उस रोगी की घोषणा करते हैं)

- Does not have insurance coverage hence we will bill the patient as per our rack rates. We may or may not consider discount for all such undertakings. (स्वास्थ्य बीमा कवरेज नहीं है इसलिए हम मरीज को अपनी रैक दरों के अनुसार बिल देंगे। हम ऐसे सभी उपक्रमों के लिए छूट पर विचार कर भी सकते हैं और नहीं भी।)

- Patient has health insurance coverage but out of own free will is opting for reimbursement/ cash paying mode. . As insured is already covered under TPA servicing for which we are network provider, hence we agree to bill this patient as per PHS or insurer agreed rate list (whichever is less). The benefit of discount as per MOU will also be given to this patient. (रोगी के पास स्वास्थ्य बीमा कवरेज है लेकिन वह अपनी मर्जी से रीइंबससमेंट/नकद भुगतान मोड का विकल्प चुन रहा है। . चूँकि बीमित व्यक्ति पहले से ही टीपीए सर्विसिंग के अंतर्गत कवर है जिसके लिए हम नेटवर्क प्रदाता हैं, इसलिए हम इस मरीज को पीएचएस या बीमाकर्ता द्वारा सहमत दर सूची (जो भी कम हो) के अनुसार बिल देने के लिए सहमत हैं। एमओयू के अनुसार छूट का लाभ भी इस मरीज को दिया जायेगा.)

Signature: ……

Name of the Hospital Representative & Hospital Seal