



- ★ To be filled in CAPITAL letters only
- ★ Seperate claim form to be filled for every insured person for accumulation of points
- ★ As per IRDA, all claims shall be settled in electronic mode only. Please provide correct bank account details

1. **Name of Policy Holder/Proposer:** _____
 Current Policy Number: _____
 Card No./UHID: _____

2. **Details of the insured person in respect of whom points to be considered:**
 Name of Insured: _____
 Relationship with the Policy Holder : _____ Present completed age (in years) : _____ Gender : M _____ F _____
 Current Residential address: _____

 City: _____ State: _____
 Pin Code: _____ Mobile No.: _____ Landline No.: _____
 E-mail: _____

3. **Details of the bills/receipts to be attached:**

Activity Heads/ Bills (As applicable)	Bill No.	Bill Date	Bill attached	Name of Hospital/Diagnostic centre/ Event organiser/ other
Heart related screening tests (under PRA [#]) above 45 years		<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	
HbA1c/ Complete lipid profile (under PRA [#]) any age		<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	
PAP Smear (under PRA) Females*		<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	
Mammogram (under PRA) Females*		<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	
Prostate Specific Antigen (PSA) (under PRA) Males**		<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	
Any other test as suggested by Our empanelled Medical expert (under PRA)		<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	
Gym/ Yoga membership for 1 year		<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	
Participation in Professional sporting events like Marathon/ Cyclothon/ Swimathon, etc.		<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	
Participation in any other health & fitness activity/ event organized by ICICI Lombard		<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	

4. Quit smoking- based on self declaration
 Share your fitness success story
 On winning any health quiz organized by ICICI Lombard

Please share details

[#] PRA refers to Preventive Risk Assessment ** Males above age 45 * Females above age 45

DECLARATION

- I hereby agree, affirm and declare that
- a) The statements / information given / stated in this claim form are true, correct and complete to the best of my knowledge and belief.
 - b) No material information which is relevant to the processing of the claim or in any manner has a bearing on the claim has been withheld or not disclosed.
 - c) If I have given/made any false or fraudulent statement/information or suppressed or concealed or in any manner failed to disclose material information, the policy shall be void and that I shall not be entitled to all/any rights to recover thereunder in respect of any or all claims, past, present or future.
 - d) The receipt of this bills/receipts/other supporting/related documents does not constitute an admission of claim liability by the company and the company reserves the right to process or reject or require further/additional information in respect of the bills/receipts.
 - e) I also consent and authorize ICICI Lombard Health Care to seek medical information from any hospital/medical practitioner who has any time attended on the insured person.
 - f) I hereby declare that I have included all the bills / receipts for the purpose of this claim & that I will not be making any supplementary claim.
 - g) I confirm that the expenses for which claim is being lodged have been incurred in respect of the insured.

Place : _____

Date : / /

Signature of Claimant/ Proposer