ICICI LOMBARD GENERAL INSURANCE COMPANY LIMITED

CLAIM FORM FOR ALL RISK INSURANCE

(The issue of this form is not to be taken as an Admission of Liability)

PLEASE ANSWER ALL QUESTIONS FULLY

Address to dispatch Claim Documents: **ICICI Lombard Health Care** **ICICI Bank Tower, Plot No.12, Financial District, Nanakram Guda, Gachibowli, Hyderabad, Andhra Pradesh PIN No. 500032.**	Cover Note / Policy No **4049/154950297/05/000** Period of Insurance Date of Incidence: Claim Number:

1.	**Details of Insured**	
(i)	Name	
(ii)	Policy No.	
(iii)	Occupation	
(iv)	Address for correspondence	
(v)	Contact Number	
2.	Nature of Claim	
3.	Details of Claim	
4.	Place & address of incidence.	
5	When was Incidence happened?	
8	Estimated value of Claim	
12.	Have you ever before sustained loss of the same nature? If so, give particulars.	

13.	Is there any other insurance policy? If so, give full particulars	
14	Any additional information relevant to processing of claim	

I/We hereby agree, affirm and declare that:

(a) The statements/information given/stated by me/us in this claim form are true, correct and complete.

(b) The details of all persons having an interest in the property in respect of which the claim is being made are provided as per the proposal form or by way of an endorsement in the policy. Furthermore, save and except as provided or disclosed in this claim form, no claim made hereunder (or the same/similar claim) has been made or lodged with any other insurance company.

(c) No material information which is relevant to the processing of the claim or which in any manner has a bearing on the claim has been withheld or not disclosed.

(d) If I/we 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/We shall not be entitled to all/any rights to recover thereunder in respect of any or all claims, past, present or future.

(e) The receipt of this claim form/other supporting/related documents does not constitute or be deemed to constitute an agreement by the Company of the claim and the Company reserves the right to process or reject or require further/additional information in respect of the claim.

Date:

Place: **Signature of the Insured**