

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		To be filled by Hospital/ Treating doctor	To track the hospital details and the treatment details related to the patient admission	
B1	Hospital Details			
B2	Doctor Details			
B3	Patient details			
B4	Treatment / Procedure Details			
B5	Required only for Retail/ Individual customers			
Page end	Hospital declaration			
Part C		To be filled by Insured	For Electronic fund transfer to the bank account	
C1	Patient's Name			
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	
	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>			
No	Please fill the C-KYC form			

Documents Submitted				
S.No.	Document	Yes	No	Type of document
1.	Claim form duly filled	<input type="checkbox"/>	<input type="checkbox"/>	Original
2.	Discharge Summary/ Daycare Summary	<input type="checkbox"/>	<input type="checkbox"/>	Original
3.	Final Hospital Bill	<input type="checkbox"/>	<input type="checkbox"/>	Original
4.	Payment Receipts	<input type="checkbox"/>	<input type="checkbox"/>	Original
5.	Investigation Reports	<input type="checkbox"/>	<input type="checkbox"/>	Original
6.	Pharmacy Bills	<input type="checkbox"/>	<input type="checkbox"/>	Original
7.	Implant Sticker/ Invoice	<input type="checkbox"/>	<input type="checkbox"/>	Original
8.	Doctor Prescriptions	<input type="checkbox"/>	<input type="checkbox"/>	Photocopy
9.	Consultation Paper	<input type="checkbox"/>	<input type="checkbox"/>	Photocopy
10.	Age Proof	<input type="checkbox"/>	<input type="checkbox"/>	Photocopy
11.	Indoor Case Paper	<input type="checkbox"/>	<input type="checkbox"/>	Photocopy
12.	EFT (Copy of cancelled cheque/ self attested ID poof/ Bank attested copy of passbook with IFSC code)	<input type="checkbox"/>	<input type="checkbox"/>	Photocopy
13.	Part D - C-KYC Form (Only for Retail/ Individual customers if claiming >₹ 1 lakh)	<input type="checkbox"/>	<input type="checkbox"/>	Original
14.	Aadhaar Card Copy of the Proposer/ Employee (Mandatory)	<input type="checkbox"/>		Photocopy
15.	PAN Card Copy of the Proposer/ Employee (Mandatory)	<input type="checkbox"/>		Photocopy

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:

Card No./ UHID of the Patient:

Gender: Male Female Date of Birth: 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

Member ID No./ Employee ID (Client ID):

Group/ Company name:

For Individual/ Retail Policy

(*Mandatory)

*Claim Intimation Service Request no.:

Is this a renewal policy: Yes No

If Yes, kindly mention your previous policy no.:

A4. Name of the Proposer*/Employee:

Aadhaar No. of the Proposer*/Employee: PAN No. of the Proposer*/Employee:

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: Time: Date of Discharge: Time:

Date of injury sustained or disease/ Illness first detected:

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: Date of commencement of first Insurance without break:

Have you been hospitalized in the last 4 years since inception of contract: Date: 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

- 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		<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	₹ <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
Doctors consultation/ Visit charges		<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	₹ <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
Investigation charges (Includes Radiology and Pathology reports)		<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	₹ <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
Surgeon and Asst. surgeon charges		<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	₹ <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
Anesthetist charges & Operation theatre charges		<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	₹ <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
Equipment charges/ Procedure charges		<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	₹ <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
Cost of implant (If any)		<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	₹ <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
Medicine charges (Includes ward and OT medicines and consumables)		<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	₹ <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
Pharmacy charges		<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	₹ <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
Taxes/ Surcharges/ Service charge		<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	₹ <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
Miscellaneous/ Other charges		<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	₹ <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
Pre hospitalization bills (If any)		<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	₹ <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
Post hospitalization bills (If any)		<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	₹ <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
Discount provided by hospital (If any)		<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	₹ <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
Total claimed amount (In ₹) (Total claimed amount should be equal to the amount in attached bill documents)				₹ <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>

MANDATORY : COPY OF AADHAAR CARD AND PAN CARD ARE REQUIRED FOR ALL CLAIMS

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*	<input type="checkbox"/>	<input type="checkbox"/>	9. Age proof (Driving License/ PAN card/ Passport/ Aadhaar copy)*	<input type="checkbox"/>	<input type="checkbox"/>
2. Aadhaar Card copy of the Proposer/ Employee*	<input type="checkbox"/>	<input type="checkbox"/>	10. Part - C (For EFT/RTGS/ NEFT)*	<input type="checkbox"/>	<input type="checkbox"/>
3. PAN Card copy of the Proposer/ Employee*	<input type="checkbox"/>	<input type="checkbox"/>	11. ICICI Lombard GIC Authorisation Letter	<input type="checkbox"/>	<input type="checkbox"/>
4. Discharge summary*	<input type="checkbox"/>	<input type="checkbox"/>	12. Implant name and invoice (if any) with implant sticker	<input type="checkbox"/>	<input type="checkbox"/>
5. Hospital bills, Final/ main hospital bill and other bills (if any)*	<input type="checkbox"/>	<input type="checkbox"/>	13. Indoor Case Papers	<input type="checkbox"/>	<input type="checkbox"/>
6. Hospital payment receipt & other receipts supporting bills*	<input type="checkbox"/>	<input type="checkbox"/>	14. Prescription papers/ Consultation papers	<input type="checkbox"/>	<input type="checkbox"/>
7. Investigation reports* (Including ECG/ CT/ MRI/ USG/ HPE)	<input type="checkbox"/>	<input type="checkbox"/>	15. C-KYC FORM (Only for Retail/Individual customers, claiming > ₹ 1Lakh)	<input type="checkbox"/>	<input type="checkbox"/>
8. Medicine/ Pharmacy bills with doctors prescription*	<input type="checkbox"/>	<input type="checkbox"/>	16. Others (details) _____	<input type="checkbox"/>	<input type="checkbox"/>

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 (If Applicable)

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: / /

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, TS-500032

^ Your Claim details are just an SMS away, Please SMS <KEYWORD> to 57 57 58

• Cashless Status: <KEYWORD> is "ILHC AL <12-digit-AL-No.>" • Claim Status: <KEYWORD> is "ILHC CL <12-digit-CL-No.>" • Payment details: <KEYWORD> is "ILHC PAY <12-digit-Claim-No.>"

(AL No. & CL No. is the one you have received on your mobile no. after intimating us)

^ To view real time claim status, please click: <https://www.icicilombard.com/IL-Health-Care/Customer/ClaimStatus>

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: ICU:

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:
 Date of Admission: / / Time: : Date of Discharge: / / Time: :
 Type of Admission: Emergency Planned Day Care Maternity
 Type of Treatment: Surgical Procedure Multiple Surgical Procedure Medical Treatment
 If Maternity, Date of Delivery: / / 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: / /
 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 diagnosis)	
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: / /

 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.

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 the 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