

CLAIM FORM – PART A
TO BE FILLED IN BY THE INSURED
 The issue of this Form is not to be taken as an admission of liability

SECTION A – DETAILS OF PRIMARY INSURED

a) Policy No. b) Sl. No/ Certificate No: c) Company/ TPA ID No.

d) Name

e) Address

Phone No. Email ID

SECTION B – DETAILS OF INSURANCE HISTORY

a) Currently covered by any other Medi Claim Health Insurance. Yes No b) Date of commencement of first insurance without break

c) If Yes, Company Name Policy No. Sum Insured

d) Have you been hospitalized in the last four years since inception of the contract Yes No Date

Diagnosis

e) Previously covered by any other Medi Claim / Health Insurance Yes No

f) If yes, Company Name

SECTION C- DETAILS OF INSURED PERSON HOSPITALISED

a) Name

b) Relationship Self Spouse Child Father Mother Other _____

c) Date of Birth d) Age

e) Address (If different than above)

f) Gender Male Female Transgender g) Occupation: Service Self Employed Homemaker Student Retired Others _____

h) Telephone No i) Mobile No.

j) E-mail ID, if any

SECTION D- DETAILS OF HOSPITALISATION

a) Name of the Hospital where admitted

b) Room Category occupied Daycare Single Occupancy Twin Sharing 3 or more beds per room

c) Hospitalisation due to Illness Injury Maternity

d) Date of Injury/ Date of disease first detected/ Date of delivery e) Date of admission f) Time

g) Date of discharge h) Time

i) If injury, give cause Self-Inflicted Road Traffic Accident Substance Abuse Alcohol Consumption

i) If Medico legal Yes No ii) Reported to police? Yes No

j) System of medicine Allopathic Other systems of medicine

SECTION E- DETAILS OF CLAIM

a) Details of the treatment expenses claimed under Hospitalisation Cover

i) Hospitalisation Expenses	ii) Ambulance Charges
iii) Pre-hospitalisation Expenses	iv) Post-hospitalisation Expenses
v) Organ Donor Expenses	vi) Air Ambulance Cover
vii) Alternative Treatments	viii) Non- Medical Expenses

- b) Claim for Domiciliary Hospitalization YES NO (if yes, please provide details in annexure)
- c) Claim for Preventive Health Check up YES NO

Please tick the applicable Optional Cover/Add on cover claimed:		
i) my:health Hospital Cash	<input type="checkbox"/>	Please mention the number of days claimed for:
ii) my:health Critical Illness Benefit	<input type="checkbox"/>	Please mention the Critical Illness claimed for:
iii) E Opinion for Critical Illness	<input type="checkbox"/>	
iv) Daily Cash for choosing Shared Accommodation	<input type="checkbox"/>	

Claim Documents Submitted Check List: Hospitalization Claim		Check list of additional documents for Critical Illness claims	
<input type="checkbox"/> Duly filled and signed Claim Form	<input type="checkbox"/> Copy of intimation letter, if any	<input type="checkbox"/> Medical certificate confirming the diagnosis of Critical Illness	
<input type="checkbox"/> Hospital Main Bill	<input type="checkbox"/> Original Hospital bill break up	<input type="checkbox"/> Certificate from attending Medical Practitioner confirming the duration of illness	
<input type="checkbox"/> Original Hospital Bill Payment Receipt	<input type="checkbox"/> Original Hospital Discharge summary	<input type="checkbox"/> First consultation letter and subsequent prescriptions	
<input type="checkbox"/> Pharmacy Bill	<input type="checkbox"/> Operation theatre notes	<input type="checkbox"/> Indoor case papers if applicable	
<input type="checkbox"/> Original Investigation / diagnostic Reports with original bills and payment receipt	<input type="checkbox"/> Doctors request for investigations	<input type="checkbox"/> FIR copy or medico legal certificate (wherever applicable)	
<input type="checkbox"/> ECG	<input type="checkbox"/> Prescriptions	<input type="checkbox"/> Photo ID and Age proof	
<input type="checkbox"/> Copy of the Network Provider's Registration Certificate	<input type="checkbox"/> MLC/FIR copy of applicable	<input type="checkbox"/> Death Summary with Death Certificate (In death claims only)	
<input type="checkbox"/> KYC Documents	<input type="checkbox"/> implant stickers for all implants used during surgeries	<input type="checkbox"/> Original invoice for Vaccination and payment receipt	

SECTION – F DETAILS OF BILLS ENCLOSED

S. No	Bill No.	Date							Issued By	Towards	Amount (Rs)			
		D	D	M	M	Y	Y							

SECTION – G DETAILS OF PRIMARY INSURED'S BANK ACCOUNT

a) PAN	b) Account Number
c) Bank Name/ Branch	d) Payable details: Cheque/ DD
e) IFSC Code	e) *please attach a cancelled cheque pertaining to the same
f) MICR No	*please attach a cancelled cheque pertaining to the same

Note: It is agreed that the Policyholder/Claimant will intimate in writing to HDFC ERGO General Insurance Co. Ltd. about any change in bank account details. In an event Insured person bears expenses for treatment please provide account details of Insured Persons in the above format along with proof of incurring such expenses..

SECTION H – DECLARATION BY THE INSURED

I hereby declare that the information furnished in this claim form is true & 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 & 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 & that I will not be making any supplementary claim except the pre/post-hospitalization claim, if any.

Date:

Place:

Signature of Insured

**CLAIM FORM – PART B
TO BE FILLED IN BY THE HOSPITAL**
The issue of this Form is not to be taken as an admission of liability
Please include the original preauthorisation request form in lieu of PART A

SECTION A – DETAILS OF HOSPITAL

a) Name of the Hospital where treated													
b) Hospital ID							c) Type of Hospital						
Network							Non Network (If non network fill section E)						
d) Name of the treating Doctor													
e) Qualification													
f) Registration No with state Code							g) Phone No:						

SECTION B – DETAILS OF PATIENT ADMITTED

a) Name of the patient																		
b) IP Registration Number													c) Gender	<input type="checkbox"/> Male	<input type="checkbox"/> Female	<input type="checkbox"/> Transgender		
d) Date of Birth	D	D	M	M	Y	Y	Y	Y	e) Age	Y	Y	M	M					
f) Date of Admission	D	D	M	M	Y	Y	Y	Y	g) Time of Admission	H	H	M	M					
h) Date of Discharge	D	D	M	M	Y	Y	Y	Y	i) Time of Discharge	H	H	M	M					
j) Type of Admission	<input type="checkbox"/> Emergency <input type="checkbox"/> Planned <input type="checkbox"/> Daycare <input type="checkbox"/> Maternity																	
k) Status at time of discharge	<input type="checkbox"/> Discharged to Home <input type="checkbox"/> Discharged to another Hospital <input type="checkbox"/> Deceased												l) Total Claimed Amount					

SECTION C – DETAILS OF AILMENTS DIAGNOSED (PRIMARY)

a) ICD 10 Codes	Primary Diagnosis	Additional Diagnosis	Co-morbidities
Details of Procedure/s done			
b) ICD 10 PCS	Procedure 1	Procedure 2	Procedure 3
c) Pre-authorization obtained	<input type="checkbox"/> Yes <input type="checkbox"/> No	d) Pre-authorization No.	
e) If authorization by network hospital not obtained, give reason			
f) Hospitalisation due to Injury	<input type="checkbox"/> Yes <input type="checkbox"/> No	g) If yes, give cause	
Self inflicted?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Road Traffic Accident	<input type="checkbox"/> Yes <input type="checkbox"/> No
		Substance Abuse / Alcohol Consumption	<input type="checkbox"/> Yes <input type="checkbox"/> No
ii) If Injury due to Substance abuse / alcohol consumption, Test Conducted to establish this:	<input type="checkbox"/> Yes <input type="checkbox"/> No (If yes, attach reports)		
iii) Medico Legal	<input type="checkbox"/> Yes <input type="checkbox"/> No		
iv) Reported to Police	<input type="checkbox"/> Yes <input type="checkbox"/> No		
v) FIR No			
vi) If not reported to Police give reasons			

SECTION D – CLAIM DOCUMENTS SUBMITTED – CHECKLIST

<input type="checkbox"/> Claim form duly filled and signed	<input type="checkbox"/> Investigation reports
<input type="checkbox"/> Original Pre authorization Request	<input type="checkbox"/> CT/MRI/USG/HPE investigation Report
<input type="checkbox"/> Copy of Pre-authorization approval Letter	<input type="checkbox"/> Doctor's reference slip for Investigation
<input type="checkbox"/> Copy of photo ID card of patient verified by Hospital	<input type="checkbox"/> ECG
<input type="checkbox"/> Hospital Discharge Summary	<input type="checkbox"/> Pharmacy Bills
<input type="checkbox"/> Operation Theatre Notes	<input type="checkbox"/> MLC Report & Police FIR
<input type="checkbox"/> Hospital Main Bill	<input type="checkbox"/> Original death summary from hospital where applicable
<input type="checkbox"/> Hospital break up Bill	<input type="checkbox"/> Any other, Pl specify

SECTION E – DETAILS IN CASE OF NON NETWORK HOSPITAL

Address of the Hospital

Phone No. Registration No. with State Code

Hospital PAN No of In-patient Beds

Facilities available in Hospital: i) OT Yes No ii) ICU Yes No

iii) Others _____

SECTION F – DECLARATION BY 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.

Date:

Place:

Signature and seal of the Hospital Authority

LIST OF ENCLOSURES FOR SUBMISSION OF CLAIM**Note:**

- When original bills, receipts, prescriptions, reports and other documents are submitted to the other insurer or to the reimbursement provider, verified photocopies attested by such other organization/provider have to be submitted.
- If original bills, receipts, prescriptions, reports and other documents are submitted to **Us** and Insured Person requires same for claiming from other organization/provider, then on request from the Insured Person **We** will provide attested copies of the bills and other documents submitted by the Insured Person.
- If below mentioned documents are not provided in full or are insufficient for **Us** to consider the claim, then **We** may request additional information or documentation.

In-patient Treatment /Day Care Procedures

- Duly filled and signed Claim Form.
- Photocopy of ID card / Photocopy of current year policy.
- Original Detailed Discharge Summary with date of admission & discharge, clinical history, past history / procedure details/ Day care summary from the hospital.
- Original consolidated hospital bill with break up of each Item, duly signed by the insured.
- Original payment Receipt of the hospital bill.
- First Consultation letter and subsequent Prescriptions.
- Original bills, original payment receipts and Reports for investigation.
- Original medicine bills and receipts with corresponding Prescriptions.
- Original invoice/Sticker of implants/bills for Implants (viz. Stent /PHS Mesh/ IOL etc.) with original payment receipts.

Road Traffic Accident

In addition to the In-patient Treatment documents:

- Copy of the First Information Report from Police Department / Copy of the Medico-Legal Certificate.

In Non Medico legal cases

- Treating Doctor's Certificate giving details of injuries (How, when and where injury sustained)

In Accidental Death cases

- Copy of Post Mortem Report & Death Certificate (If conducted)

For Death Cases

In addition to the In-patient Treatment documents:

- Original Death Summary from the hospital.
- Copy of the Death certificate from treating doctor or the hospital authority.
- Copy of the Legal heir certificate, if the claim is for the death of the principle insured.

Pre and Post-hospitalization/Vaccination

- Duly filled and signed Claim Form.
- Photocopy of ID card / Photocopy of current year policy.
- Original Medicine bills, original payment receipt with prescriptions.
- Original Investigations bills, original payment receipt with prescriptions and report.
- Original Consultation documents and bills, original payment receipt with prescription.
- Copy of the Discharge Summary of the main claim. (except for out patient dental claim)

Organ Donation/Transplantation

In addition to the documents of general hospitalization

- Organ Function test / blood test proving organ failure.
- Treatment Certificate issued by the Transplant Surgeon of the hospital concerned.

Ambulance Benefit

- Duly filled and signed Claim Form.
- Photocopy of ID card / Photocopy of current year policy.

- Original Bill with Original Payment Receipt.
- Treating Doctor's consultation prescription indicating Emergency Hospitalization.

Critical Illness Benefit

- Duly filled and signed Claim Form.
- Medical certificate confirming the diagnosis of Critical Illness
- Certificate from attending Medical Practitioner confirming that the duration of Illness
- Discharge certificate/ card from the Hospital, if any
- Investigation test reports confirming the diagnosis,
- First consultation letter and subsequent prescriptions
- Indoor case papers if applicable
- Specific documents to confirm the diagnosis of respective Critical Illness
- In the cases where Critical Illness arises due to an accident, FIR copy or medico legal certificate ,wherever conducted.

Preventive Health Check up

- Duly filled and signed Claim Form.
- Health check up test reports
- Original bill and receipt from the diagnostic centre.

CUSTOMER IDENTIFICATION PROCEDURE (AS PER KYC NORMS OF IRDAI)

Please submit the following documents in case of claim amount exceeds Rs. 100,000: KYC form along with photocopy of any one KYC document (eg., passport, driving license, voter ID, etc) along with PAN card or Form 60, Or provide CKYC number if available.

Legal name and any other names used (Any one of the mentioned documents)	Passport/ PAN Card/ Voter's Identity Card/ Driving License/ Letter from a recognized public authority or public servant verifying the identity and residence of the customer
Proof of Residence (Any one of the mentioned documents)	Telephone bill/ Bank account statement/ Letter from any recognized public authority/ Electricity bill/ Ration card

CENTRAL KYC REGISTRY | Know Your Customer (KYC) Application Form | Individual

Important Instructions:

- A) Fields marked with "*" are mandatory fields.
- B) Please fill the form in English and in BLOCK letters.
- C) Please fill the date in DD-MM-YYYY format.
- D) Please read section wise detailed guidelines / instructions at the end
- E) List of State / U.T code as per Indian Motor Vehicle Act, 1988 is available at the end.
- F) List of two character ISO 3166 country codes is available at the end.
- G) KYC number of applicant is mandatory for update application.
- H) For particular section update, please tick (✓) in the box available before the section number and strike of the sections not required to be updated.



For office use only (To be filled by financial institution)

Application Type* New Update

KYC Number (Mandatory for KYC update request)

Account Type* Normal Simplified (for low risk customers) Small

1. PERSONAL DETAILS (Please refer instruction A at the end)

	Prefix	First Name	Middle Names	Last Name	
Name* (Same as ID proof)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<div style="border: 1px solid gray; padding: 5px; width: fit-content; margin: 0 auto;">PHOTO</div> <div style="border: 1px solid gray; height: 100px; width: 100%; margin: 5px auto;"></div> <div style="border: 1px solid gray; padding: 2px; width: fit-content; margin: 0 auto;">Signature / Thumb Impression</div>
Maiden Name (if any*)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	
Father / Spouse Name*	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	
Mother Name*	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	
Date of Birth*	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	
Gender*	<input type="checkbox"/> M- Male <input type="checkbox"/> F- Female <input type="checkbox"/> T-Transgender				
Marital Status*	<input type="checkbox"/> Married <input type="checkbox"/> Unmarried <input type="checkbox"/> Others				
Citizenship*	<input type="checkbox"/> IN- Indian <input type="checkbox"/> Others (ISO 3166 COUNTRY CODE <input type="text"/>)				
Residential Status*	<input type="checkbox"/> Resident Individual <input type="checkbox"/> Non Resident Indian		<input type="checkbox"/> Foreign National <input type="checkbox"/> Person of Indian Origin		
Occupation Type*	<input type="checkbox"/> S-Services (<input type="checkbox"/> Private Sector <input type="checkbox"/> Public Sector <input type="checkbox"/> Government Sector)		<input type="checkbox"/> O-Others (<input type="checkbox"/> Professional <input type="checkbox"/> Self Employed <input type="checkbox"/> Retired <input type="checkbox"/> Housewife <input type="checkbox"/> Student)		
	<input type="checkbox"/> B-Business <input type="checkbox"/> X- Not Categorised				

2. TICK IF APPLICABLE RESIDENCE FOR TAX PURPOSES IN JURISDICTION(S) OUTSIDE INDIA (Please refer instruction B at the end)

ADDITIONAL DETAILS REQUIRED* (Mandatory only if section 2 is ticked)

ISO 3166 Country Code of Jurisdiction of Residence*

Tax Identification Number of equivalent (if issued by jurisdiction)*

Place / City of Birth* ISO 3166 Country Code of Birth*

3. PROOF OF IDENTITY (PoI)* (Please refer instruction C at the end)

(Certified copy of any one of the following Proof of Identity [PoI] needs to be submitted)

<input type="checkbox"/> A- Passport Number <input type="text"/>	Passport Expiry Date <input type="text"/>
<input type="checkbox"/> B- Voter ID Card <input type="text"/>	
<input type="checkbox"/> C- PAN Card <input type="text"/>	
<input type="checkbox"/> D- Driving Licence <input type="text"/>	Driving Licence Expiry Date <input type="text"/>
<input type="checkbox"/> E- UID (Aadhaar) <input type="text"/>	
<input type="checkbox"/> F- NREGA Job Card <input type="text"/>	
<input type="checkbox"/> Z- Others (any document notified by the central government) <input type="text"/>	Identification Number <input type="text"/>
<input type="checkbox"/> S- Simplified Measures Account - Document Type code <input type="text"/>	Identification Number <input type="text"/>

4. PROOF OF ADDRESS (PoA)*

4.1 CURRENT / PERMANENT / OVERSEAS ADDRESS DETAILS (Please see instruction D at the end)

(Certified copy of any one of the following Proof of Address [PoA] needs to be submitted)

Address Type* Residential / Business Residential Business Registered Office Unspecified

Proof of Address* Passport Driving Licence UID (Aadhaar)

Voter Identity Card NREGA Job Card Others

Simplified Measures Account - Document Type code

Address

Line 1*

Line 2*

Line 3* City / Town / Village*

District* Pin / Post Code* State / U.T Code* ISO 3166 Country Code*

CENTRAL KYC REGISTRY | Instructions / Check list / Guidelines for filling individual KYC Application Form

General Instructions:

- 1 Fields marked with are mandatory fields.
- 2 Tick '✓' wherever applicable.
- 3 Self-Certification of documents is mandatory.
- 4 Please fill the form in English and in BLOCK Letters.
- 5 Please fill all dates in DD-MM-YYYY format.
- 6 Wherever state code and country code is to be furnished, the same should be the two-digit code as per Indian Motor Vehicle, 1988 and ISO 3166 country code respectively list of which is available at the end.
- 7 KYC number of applicant is mandatory for updation of KYC details.
- 8 For particular section update, please tick (✓) in the box available before the section number and strike off the sections not required to be updated.
- 9 In case of 'Small Account type' only personal details at section number 1 and 2, photograph, signature and self-certification required.

A Clarification / Guidelines on filling 'Personal Details' section

- 1 **Name:** Please state the name with Prefix (Mr/Mrs/Ms/Dr/etc.). The name should match the name as mentioned in the Proof of Identity submitted failing which the application is liable to be rejected.
- 2 Either father's name or spouse's name is to be mandatorily furnished. In case PAN is not available father's name is mandatory.

B Clarification / Guidelines on filling details if applicant residence for tax purposes in jurisdiction(s) outside India

- 1 **Tax identification Number (TIN):** TIN need not be reported if it has not been issued by the jurisdiction. However, if the said jurisdiction has issued a high integrity number with an equivalent level of identification (a "Functional equivalent"), the same may be reported. Examples of that type of number for individual include, a social security/insurance number, citizen/personal identification/services code/number, and resident registration number)

C Clarification / Guidelines on filling 'Proof of Identity [Pol]' section

- 1 If driving license number or passport is provided as proof of identity then expiry date is to be mandatorily furnished.
- 2 Mention identification / reference number if 'Z- Others (any document notified by the central government)' is ticked.
- 3 In case of Simplified Measures Accounts for verifying the identity of the applicant, any one of the following documents can also be submitted and undernoted relevant code may be mentioned in point 3 (S).

Document Code	Description
01	Identity card with applicant's photograph issued by Central / State Government Departments, Statutory / Regulatory Authorities, Public Sector Undertakings, Scheduled Commercial Banks, and Public Financial Institutions.
02	Letter issued by a gazetted officer, with a duly attested photograph of the person.

D Clarification / Guidelines on filling 'Proof of Address (PoA) - Current / Permanent / Overseas Address details' section

- 1 PoA to be submitted only if the submitted Pol does not have an address or address as per Pol is invalid or not in force.
- 2 State / U.T Code and Pin / Post Code will not be mandatory for Overseas addresses.
- 3 In case of Simplified Measures Accounts for verifying the address of the applicant, any one of the following documents can also be submitted and undernoted relevant code may be mentioned in point 4.1.

Document Code	Description
01	Utility bill which is not more than two months old of any service provider (electricity, telephone, post-paid mobile phone, piped gas, water bill).
02	Property or Municipal Tax receipt.
03	Bank account or Post Office savings bank account statement.
04	Pension or family pension payment orders (PPOs) issued to retired employees by Government Departments or Public Sector Undertakings, if they contain the address.
05	Letter of allotment of accommodation from employer issued by State or Central Government departments, statutory or regulatory bodies, public sector undertakings, scheduled commercial banks, financial institutions and listed companies. Similarly, leave and license agreements with such employers allotting official accommodation.
06	Documents issued by Government departments of foreign jurisdictions and letter issued by Foreign Embassy or Mission in India.

E Clarification / Guidelines on filling 'Proof of Address [PoA] - Correspondence / Local Address details' section

- 1 To be filled only in case the PoA is not the local address or address where the customer is currently residing. No separate PoA is required to be submitted.
- 2 In case of multiple correspondence / local addresses. Please fill 'Annexure A1'

F Clarification / Guidelines on filling 'Contact details' section

- 1 Please mention two- digit country code and 10 digit mobile number (e.g. for Indian mobile number mention 91-9999999999).
- 2 Do not add '0' in the beginning of Mobile number.

G Clarification / Guidelines on filling 'Related Person details' section

- 1 Provide KYC number of related person if available.

H Clarification / Guidelines on filling 'Related Person details - Proof of Identity [Pol] of Related Person' section

- 1 Mention identification / reference number if Z- Others (any document notified by the central government)' is ticked.

List of two - digit state / U.T codes as per Indian Motor Vehicle Act, 1988

State / U.T	Code	State / U.T	Code	State / U.T	Code
Andaman & Nicobar	AN	Himachal Pradesh	HP	Pondicherry	PY
Andhra Pradesh	AP	Jammu & Kashmir	JK	Punjab	PB
Arunachal Pradesh	AR	Jharkhand	JH	Rajasthan	RJ
Assam	AS	Karnataka	KA	Sikkim	SK
Bihar	BR	Kerala	KL	Tamil Nadu	TN
Chandigarh	CH	Lakshadweep	LD	Telangana	TS
Chattisgarh	CG	Madhya Pradesh	MP	Tripura	TR
Dadra and Nagar Haveli	DN	Maharashtra	MH	Uttar Pradesh	UP
Daman & Diu	DD	Manipur	MN	Uttarakhand	UA
Delhi	DL	Meghalaya	ML	West Bengal	WB
Goa	GA	Mizoram	MZ	Other	XX
Gujarati	GJ	Nagaland	NL		
Haryana	HR	Orissa	OR		

List of ISO 3166 two-digit Country Code

Country	Country Code	Country	Country Code	Country	Country Code	Country	Country Code
Afghanistan	AF	Dominican Republic	DO	Libya	LY	Saint Pierre and Miquelon	PM
Aland Islands	AX	Ecuador	EC	Liechtenstein	LI	Saint Vincent and the Grenadines	VC
Albania	AL	Egypt	EG	Lithuania	LT	Samoa	WS
Algeria	DZ	El Salvador	SV	Luxembourg	LU	San Marino	SM
American Samoa	AS	Equatorial Guinea	GQ	Macao	MO	Sao Tome and Principe	ST
Andorra	AD	Eritrea	ER	Macedonia, the former Yugoslav Republic of	MK	Saudi Arabia	SA
Angola	AO	Estonia	EE	Madagascar	MG	Senegal	SN
Anguilla	AI	Ethiopia	ET	Malawi	MW	Serbia	RS
Antarctica	AQ	Falkland Islands (Malvinas)	FK	Malaysia	MY	Seychelles	SC
Antigua and Barbuda	AG	Faroe Islands	FO	Maldives	MV	Sierra Leone	SL
Argentina	AR	Fiji	FJ	Mali	ML	Singapore	SG
Armenia	AM	Finland	FI	Malta	MT	Sint Maarten (Dutch part)	SX
Aruba	AQ	France	FR	Marshall Islands	MH	Slovakia	SK
Australia	AU	French Guiana	GF	Martinique	MQ	Slovenia	SI
Austria	AT	French Polynesia	PF	Mauritania	MR	Solomon Islands	SB
Azerbaijan	AZ	French Southern Territories	TF	Mauritius	MU	Somalia	SO
Bahamas	BS	Gabon	GA	Mayotte	YT	South Africa	ZA
Bahrain	BH	Gambia	GM	Mexico	MX	South Georgia and the South Sandwich Islands	GS
Bangladesh	BD	Georgia	GE	Micronesia, Federated States of	FM	South Sudan	SS
Barbados	BB	Germany	DE	Moldova, Republic of	MD	Spain	ES
Belarus	BY	Ghana	GH	Monaco	MC	Sri Lanka	LK
Belgium	BE	Gibraltar	GI	Mongolia	MN	Sudan	SD
Belize	BZ	Greece	GR	Montenegro	ME	Suriname	SR
Benin	BJ	Greenland	GL	Montserrat	MS	Svalbard and Jan Mayen	SJ
Bermuda	BM	Grenada	GD	Morocco	MA	Swaziland	SZ
Bhutan	BT	Guadeloupe	GP	Mozambique	MZ	Sweden	SE
Bolivia, Plurinational State of	BO	Guam	GU	Myanmar	MM	Switzerland	CH
Bonair, Sint Eustatius and Saba	BQ	Guatemala	GT	Namibia	NA	Syrian Arab Republic	SY
Bosnia and Herzegovina	BA	Guernsey	GG	Nauru	NR	Taiwan, Province of China	TW
Botswana	BW	Guinea	GN	Nepal	NP	Tajikistan	TJ
Bouvet Island	BV	Guinea-Bissau	GW	Netherlands	NL	Tanzania, United Republic of	TZ
Brazil	BR	Guyana	GY	New Caledonia	NC	Thailand	TH
British Indian Ocean Territory	IO	Haiti	HT	New Zealand	NZ	Timor - Leste	TL
Brunei Darussalam	BN	Heard Island and McDonald Islands	HM	Nicaragua	NI	Togo	TG
Bulgaria	BG	Holy See (Vatican City State)	VA	Niger	NE	Tokelau	TK
Burkina Faso	BF	Honduras	HN	Nigeria	NG	Tonga	TO
Burundi	BI	Hong Kong	HK	Niue	NU	Trinidad and Tobago	TT
Cabo Verde	CV	Hungary	HU	Norfolk Island	NF	Tunisia	TN
Cambodia	KH	Iceland	IS	Northern Mariana Islands	MP	Turkey	TR
Cameroun	CM	India	IN	Norway	NO	Turkmenistan	TM
Canada	CA	Indonesia	ID	Oman	OM	Turks and Caicos Islands	TC
Cayman Islands	KY	Iran, Islamic Republic of	IR	Pakistan	PK	Tuvalu	TV
Central African Republic	CF	Iraq	IQ	Palau	PW	Uganda	UG
Chad	TD	Ireland	IE	Palestine, State of	PS	Ukraine	UA
Chile	CL	Isle of Man	IM	Panama	PA	United Arab Emirates	AE
China	CN	Israel	IL	Papua New Guinea	PG	United Kingdom	GB
Christmas Island	CX	Italy	IT	Paraguay	PY	United States	US
Cocos (Keeling) Islands	CC	Jamaica	JM	Peru	PE	United States Minor Outlying Islands	UM
Colombia	CO	Japan	JP	Philippines	PH	Uruguay	UY
Comoros	KM	Jersey	JE	Pitcairn	PN	Uzbekistan	UZ
Congo	CG	Jordan	JO	Poland	PL	Vanuatu	VU
Congo, the Democratic Republic of the	CD	Kazakhstan	KZ	Portugal	PT	Venezuela, Bolivarian Republic of	VE
Cook Islands	CK	Kenya	KE	Puerto Rico	PR	Viet Nam	VN
Costa Rica	CR	Kiribati	KI	Qatar	QA	Virgin Islands, British	VG
Cote d'Ivoire	CI	Korea, Democratic People's Republic of	KP	Reunion	RE	Virgin Islands, U.S.	VI
Croatia	HR	Korea, Republic of	KR	Romania	RO	Walls and Futana	WF
Cuba	CU	Kuwait	KW	Russian Federation	RU	Western Sahara	EH
Curacao	CW	Kyrgyzstan	KG	Rwanda	RW	Yemen	YE
Cyprus	CY	Lao People's Democratic Republic	LA	Saint Barthelemy	BL	Zambia	ZM
Czech Republic	CZ	Latvia	LV	Saint Helena, Ascension and Tristan da Cunha	SH	Zimbabwe	ZW
Denmark	DK	Lebanon	LB	Saint Kitts and Nevis	KN		
Djibouti	DJ	Lesotho	LS	Saint Lucia	LC		
Dominica	DM	Liberia	LR	Saint Martin (French part)	MF		

Annexure B1

CENTRAL KYC REGISTRY | Know Your Customer (KYC) Application Form | Individual | Related Person

Important Instructions:

- A) Fields marked with "*" are mandatory fields.
- B) Please fill the form in English and in BLOCK letters.
- C) Please fill the date in DD-MM-YYYY format.
- D) Please read section wise detailed guidelines / instructions at the end
- E) List of State / U.T code as per Indian Motor Vehicle Act. 1988 is available at the end.
- F) List of two character ISO 3166 country codes is available at the end.
- G) KYC number of applicant is mandatory for update application.
- H) For particular section update, please tick (✓) in the box available before the section number and strike of the sections not required to be updated.



For office use only Application Type* New Update
 (To be filled by financial institution) KYC Number (Mandatory for KYC update request)

1. DETAILS OF RELATED PERSON (Please refer instruction G at the end)

Addition of Related Person Deletion of Related person KYC Number of Related Person (if available*)

Related Person Type* Guardian of Minor Assignee Authorized Representative

Name* Prefix First Name Middle Name Last Name

(If KYC number and name are provided, below details of section 1 are optional)

PROOF OF IDENTITY (POI) OF RELATED PERSON* (Please see instruction (H) at the end)

A- Passport Number Passport Expiry Date DD - MM - YY YY

B- Voter ID Card

C- PAN Card

D- Driving Licence Driving Licence Expiry Date DD - MM - YY YY

E- UID (Aadhaar)

F- NREGA Job Card

Z- Others (any document notified by the central government) Identification Number

S- Simplified Measures Account - Document Type code Identification Number

2. APPLICANT DECLARATION

I hereby declare that the details furnished above are true and correct to the best of my knowledge and belief and I undertake to inform you of any changes therein, immediately. In case any of the above information is found to be false or untrue or misleading or misrepresenting, I am aware that I may be held liable for it.

[Signature / Thumb Impression]

Date : DD - MM - YY YY

Place :

Signature / Thumb Impression of Applicant

3. ATTESTATION / FOR OFFICE USE ONLY

Documents Received Certified Copies

KYC VERIFICATION CARRIED OUT BY

Date : DD - MM - YY YY

Emp. Name

Emp. Code

Emp. Designation

Emp. Branch

INSTITUTION DETAILS

Name

Code