To ensure priority processing, please complete all sections in CAPITAL letters. Please tick ☑ in the relevant boxes.

CLAIM FORM FOR HEALTH INSURANCE POLICIES

OTHER THAN TRAVEL AND PERSONAL ACCIDENT

The issue of this form is not to be taken as an admission of liability.

(Guidance for filling claim form - **Part A** is available on our website: www.royalsundaram.in)

Royal Sundaram
General Insurance

Please note that accepting claim intimation does not indicate claim admissibility. Claim will be processed as per policy terms and conditions. Also, please note that claims arising from "Excluded hospitals" will not be approved, as per policy terms and conditions. Please refer our website www.royalsundaram.in for list of Excluded hospitals.

PART A

DETAILS OF PRIMARY INSURED (PROPOSER) — **(TO BE FILLED IN BY THE INSURED)**

SECTION A

a) Policy No. | b) Sl. No./ Certificate No.

c) Membership No./ TPA ID No.

d) Name

e) Address

City | State

Pin Code | Land Line (with STD Code)

MOST IMPORTANT

Mobile No. | WhatsApp No. | Claims status will be shared on WhatsApp no wherever possible

PLEASE PROVIDE ACTIVE EMAIL ID ONLY AS CLAIMS CORRESPONDENCE WILL BE DONE TO THIS EMAIL ID.

Email ID

Alternate Email ID

DETAILS OF INSURANCE HISTORY (MANDATORY)

SECTION B

a) Currently covered by any other Mediclaim/Health Insurance ☐ Yes ☐ No

b) If yes, Company Name

Policy No. | c) Date of commencement of first Insurance without break (D D M M Y Y Y Y)

d) Sum Insured (Rs.) | e) Have you been hospitalized in the last four years since inception of the contract? ☐ Yes ☐ No f) Date (D D M M Y Y Y Y)

g) Diagnosis

DETAILS OF INSURED PERSON HOSPITALIZED

SECTION C

a) Name

b) Gender ☐ Male ☐ Female | c) Age (Y Y Years) (M M Months) | d) Date of Birth (D D M M Y Y Y Y)

e) Relationship to Primary insured ☐ Self ☐ Spouse ☐ Child ☐ Father ☐ Mother ☐ Other (Please Specify) _____

f) Communication Address

City | State

Pin Code | Land Line (with STD Code)

g) Occupation ☐ Doctor ☐ Service ☐ Self Employed ☐ Homemaker ☐ Student ☐ Retired ☐ Other (Please Specify) _____

h) Name of the Employer

i) Address of the Employer

DETAILS OF HOSPITALIZATION

SECTION D

a) Name & Address of Hospital where Admitted

City | State

Pin Code | Land Mark

b) Room Category occupied ☐ Day care ☐ Single occupancy ☐ 3 or more beds per room ☐ Any other category, Pls specify _____

c) Hospitalization due to ☐ Injury ☐ Illness ☐ Maternity | d) Date of Injury/Date Disease first detected (D D M M Y Y Y Y)

e) Date of Admission (D D M M Y Y Y Y) Time (H H : M M) | f) Date of Discharge (D D M M Y Y Y Y) Time (H H : M M)

g) In case of maternity, 1 Date of Delivery (D D M M Y Y Y Y) | 2 Gravida Status _____

h) If Injury, give cause ☐ Self inflicted ☐ Road Traffic Accident ☐ Substance Abuse/Alcohol Consumption

1. If Medico legal ☐ Yes ☐ No 2. Reported to police ☐ Yes ☐ No 3. MLC Report & Police FIR attached ☐ Yes ☐ No

i) System of Medicine _____

DETAILS OF CLAIM

a) Details of the treatment expenses claimed

1. Pre-hospitalization Expenses	Rs.	2. Hospitalization Expenses	Rs.
3. Post-hospitalization Expenses	Rs.	4. Health-Check up Cost	Rs.
5. Ambulance Charges	Rs.	6. Others	Rs.
		Total amount claimed	Rs.

b) Claim for Domiciliary Hospitalization ☐ Yes ☐ No (If yes, please provide summary of bills in separate sheet)

c) Details of Lump sum / cash benefit claimed:

1. Hospital Daily Cash	Rs.	2. Surgical Cash	Rs.
3. Critical Illness Benefit	Rs.	4. Convalescence	Rs.
5. Pre/Post hospitalization Lump sum benefit:	Rs.	6. Others_____	Rs.
		Total amount claimed	Rs.

No of days (Pre Hospitalisation)_____

No of days (Post Hospitalisation)_____

SECTION E

Check List of Claim Documents to be submitted (In original)* - Please tick relevant box
(For Hospital Cash benefit, photocopies of claim documents are acceptable)

- ☐ Claim Form Duly signed
- ☐ Advance payment Receipt **(Mandatory)**
- ☐ Pharmacy Bill
- ☐ Doctor's prescription for medicines purchased outside the hospital and investigation done outside hospital
- ☐ Cancelled Cheque leaf of the bank account held in the name of the primary insured **(Mandatory)**
- ☐ CKYC Registration Number of the Proposer (In case already registered for CKYC - enter register numbers):
- ☐ CKYC Registration Number is not available
  CKYC documents – Address proof and ID proof along with duly filled CKYC Registry Form with recent colour PP size photograph (for claims exceeding Rs.1 Lakh only)
- ☐ Copy of the claim intimation, if any
- ☐ Final Bill Payment Receipt **(Mandatory)**
- ☐ Doctor's request for investigation
- ☐ Original Death Summary (Wherever applicable)
- ☐ Hospital Main Bill ☐ Hospital Break-up Bill
- ☐ Hospital Discharge Summary
- ☐ Investigation Reports (Including CT/MRI/USG/HPE/ECG)
- ☐ Test report and prescription relating to first consultation for the illness
- ☐ FIR/MLC in case of accident injury and English translation of the same if it is in any other language

***Please retain copy of complete set of claim documents for your records**

DETAILS OF BILLS ENCLOSED

Sl. No	Bill No	Date	Issued by	Towards	Amount (Rs)
1		D D M M Y Y Y Y		Hospital Main Bill	
2		D D M M Y Y Y Y		Pre-hospitalization Bills: (Nos____)	
3		D D M M Y Y Y Y		Post-hospitalization Bills: (Nos____)	
4		D D M M Y Y Y Y		Pharmacy Bills: (Nos_____)	
5		D D M M Y Y Y Y			

Hospital Main Bill Payment Receipts only

Receipt No	Date	Amount	Please Tick Relevant Box
	D D M M Y Y Y Y		☐ Advance Receipt ☐ Final Receipt
	D D M M Y Y Y Y		☐ Advance Receipt ☐ Final Receipt
	D D M M Y Y Y Y		☐ Advance Receipt ☐ Final Receipt
	D D M M Y Y Y Y		☐ Advance Receipt ☐ Final Receipt

Note : Please attach separate sheet if necessary

SECTION F

PLEASE PROVIDE YOUR BANK DETAILS: (PLEASE ATTACH CANCELLED CHEQUE LEAF OF BANK ACCOUNT IN THE NAME OF PRIMARY INSURED WITHOUT FAIL)

a) PAN b) Account Number

c) Bank Name and Branch

d) IFSC Code

SECTION G

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 D D M M Y Y Y Y Place

Signature of primary insured /proposer

SECTION H

To ensure priority processing, please complete all sections in CAPITAL letters. Please tick ☑ in the relevant boxes.

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

(Guidance for filling claim form- **Part B** is available on our website: www.royalsundaram.in)

Royal Sundaram
General Insurance

SECTION A

DETAILS OF HOSPITAL

a) Name of the hospital

b) Hospital ID
(For Office use only)

c) Type of Hospital ☐ Network ☐ Non Network (If non network fill section D)

d) Name of the treating Doctor

e) Qualification

f) Registration No. with State Code

g) Phone

SECTION B

DETAILS OF THE PATIENT ADMITTED

a) Name of the Patient:

b) IP Registration Number

c) Gender ☐ Male ☐ Female d) Age Y Y Years M M Months e) Date of Birth D D M M Y Y Y Y

f) Type of Admission ☐ Emergency ☐ Planned ☐ Day Care ☐ Maternity

g) Date of Admission D D M M Y Y Y Y Time H H : M M

h) Date of Discharge D D M M Y Y Y Y Time H H : M M

i) If Maternity

1.Date of Delivery D D M M Y Y Y Y 2.Gravida Status _____

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

SECTION C

DETAILS OF AILMENT DIAGNOSED

	ICD 10 Codes	Description	Duration
1. Primary Diagnosis			M M Y Y Y Y
2. Additional Diagnosis			M M Y Y Y Y
3. Co-morbidities			M M Y Y Y Y
4. Co-morbidities			M M Y Y Y Y
	ICD 10 PCS Codes		
1. Procedure(1)			
2. Procedure(2)			
3. Procedure(3)			
4. Details of any other Procedure			

a) Whether preauthorisation obtained ☐ Yes ☐ No. If yes, Preauthorisation No._____

b) If Authorisation by network hospital not obtained, please give reason_____

c) Hospitalization due to Injury ☐ Yes ☐ No If Yes, give cause _____

1. ☐ Self-inflicted ☐ Road Traffic Accident ☐ Substance abuse/alcohol consumption

2. If Injury due to Substance abuse/alcohol consumption, Test Conducted to establish this: ☐ Yes ☐ No

If Yes, details of tests conducted_____

3. If Medico legal ☐ Yes ☐ No 4. Reported to Police ☐ Yes ☐ No 5. FIR No.

6. If not reported to police, give reason_____

d) When did the patient start suffering with the complaint? _____ Date of first consultation (prior to hospitalisation) D D M M Y Y Y Y

e) Please give previous medical history of the patient

f) Is the patient suffering from any of the following diseases. If "yes" Please mention the duration below.

		Say Yes/No	Duration in Year	Duration in Month
1.	Bronchial Asthma			
2.	Chronic Obstructive Pulmonary disease			
3.	Hypertension			
4.	Diabetes			
5.	Heart ailment			
6.	Arthritis of any kind			
7.	Cerebro vascular attack			
8.	Seizure disorder			
9.	Renal/Kidney Disorder			
10.	Congenital conditions			
11.	Developmental anomalies			
12.	Any other			

g) Is the ailment a complication / sequel of a pre-existing disease or condition? If Yes , please give details

h) History of alcoholism ☐ Yes ☐ No
If yes : No of years _____
Quantity consumed per day _____

i) History of Smoking/ Tobacco chewing ☐ Yes ☐ No
If yes : No of years _____
Units consumed per day _____

SECTION D

ADDITIONAL DETAILS IN CASE OF NON-NETWORK HOSPITAL

a) Address of the Hospital

b) Hospital Registration No

c) Hospital Registered with

City State

d) Hospital PAN e) Number of Inpatient beds

f) Facilities available in the hospital: 1. OT ☐ Yes ☐ No 2. ICU ☐ Yes ☐ No 3. Round the clock Doctor/Nurses ☐ Yes ☐ No
4. Maintains daily record of patients ☐ Yes ☐ No
5. Others _____

SECTION E

DECLARATION BY THE HOSPITAL **(PLEASE READ VERY CAREFULLY)**

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, insured's right to claim under this policy shall be for feited.

Date D D M M Y Y Y Y Place

Signature and Seal of the Hospital Authority

Royal Sundaram
General Insurance

Authorization Letter (Mandatory)

Date:

From:

To:

The Manager/ Medical Superintendent,
Medical Records

Dear Sir

Reg : Authorization Letter.

Name of the Patient:_____

IP Number_____ (First admission) in _____Hospital

IP Number_____ (Second admission) in _____Hospital

IP Number_____(Third admission) in _____Hospital

I consent and authorize M/s Royal Sundaram General Insurance Co. Limited and their Authorized Service Providers to seek medical information from your hospital and share copies of indoor case sheets and such other relevant medical records and/or meet/obtain statement from the Medical Practitioner who has at any time attended on the patient for the hospitalization dated ..... to .....

Thanking you,

Yours sincerely,

Signature of the Proposer

Signature of the Patient

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

Important Instructions:

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

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

Application Type* ☐ New ☐ Update
KYC Number (Mandatory for KYC update request)
Account Type* ☐ Normal ☐ Minor ☐ Aadhaar OTP based e-KYC (in non-face to face mode)

☐ 1. PERSONAL DETAILS* (please refer instruction **A** at the end)

	Prefix	First Name	Middle Name	Last Name
☐ Name* (Same as ID proof)				
Maiden Name				
Father / Spouse Name				
Mother Name				

Date of Birth* D D – M M – Y Y Y Y
Gender* ☐ M- Male ☐ F- Female ☐ T-Transgender
PAN* ☐ Form 60 furnished

☐ 2. PROOF OF IDENTITY AND ADDRESS* (Please refer instruction **B** at the end)

I. Certified copy of OVD or equivalent e-document of OVD or OVD obtained through digital KYC process needs to be submitted (anyone of the following OVDs)

- ☐ A- Passport Number
- ☐ B-Voter ID Card
- ☐ C-Driving Licence
- ☐ D-NREGA Job Card
- ☐ E-National Population Register Letter
- ☐ F-Proof of Possession of Aadhaar

II ☐ E-KYC Authentication
III ☐ Offline verification of Aadhaar

☐ PHOTO*

Address

Line 1*
Line 2
Line 3 City / Town / Village*
District* Pin/Post Code* State/U.T Code* ISO 3166 Country Code*

☐ 3. CURRENT ADDRESS DETAILS (Please refer instruction **B** at the end)

☐ Same as above mentioned address (In such cases address details as below need not be provided)

I. Certified copy of OVD or equivalent e-document of OVD or OVD obtained through digital KYC process needs to be submitted (anyone of the following OVDs)

- ☐ A- Passport Number
- ☐ B-Voter ID Card
- ☐ C- Driving Licence
- ☐ D-NREGA Job Card
- ☐ E- National Population Register Letter
- ☐ F - Proof of Possession of Aadhaar

II ☐ E-KYC Authentication
III ☐ Offline verification of Aadhaar
IV ☐ Deemed Proof of Address - 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*

☐ 4. CONTACT DETAILS (All communications will be sent to Mobile number/ Email-ID provided) (Please refer instruction **C** at the end)

Tel. (Off) — Tel. (Res) — Mobile —

Email ID

☐ 5. REMARKS (If any)

6. 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. Incase 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.
- I hereby consent to receiving information from Central KYC Registry through SMS/Email on the above registered number/email address.

[Signature / Thumb Impression]

Signature / Thumb Impression of Applicant

Date : D D — M M — Y Y Y Y Place:

7. ATTESTATION / FOR OFFICE USE ONLY

Documents Received ☐ Certified Copies ☐ E-KYC data received from UIDAI ☐ Data received from Offline verification ☐ Digital KYC Process ☐ Equivalent e-document

KYC VERIFICATION CARRIED OUT BY	
Date	D D — M M — Y Y Y Y
Emp. Name	
Emp. Code	
Emp. Designation	
Emp. Branch	

[Employee Signature]

INSTITUTION DETAILS	
Name	
Code	

[Institution Stamp]

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

A Clarification / Guidelines on filling 'Personal Details' section

1. Name: The name should match the name as mentioned in the Proof of Identity submitted failing which the application is liable to be rejected.
2. One the following is mandatory : Mother's name, Spouse's name, Father's name.

B Clarification / Guidelines on filling 'Current Address details' section

1. In case of deemed PoA such as utility bill, the document need not be uploaded on CKYCR
2. PoA to be submitted only if the submitted PoI does not have current address or address as per PoI is invalid or not in force.
3. State / U.T Code and Pin / Post Code will not be mandatory for Overseas addresses.
4. In Section 2, one of I, II, and III is to be selected. In case of online e-kyc authentication, II is to be selected.
5. In Section 3, one I, II, III and IV is to be selected. In case of online e-kyc authentication, II is to be selected.
6. List of documents for 'Deemed Proof of Address':

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	Pension or family pension payment orders (PPOs) issued to retired employees by Government Departments or Public Sector Undertakings, if they contain the address.
04	Letter of allotment of accommodation from employer issued by State Government or Central Government Departments, statutory or regulatory bodies, public sector undertakings, scheduled commercial banks, financial institutions and listed companies and leave and licence agreements with such employers allotting official accommodation.

7. Regulated Entity (RE) shall redact (first 8 digits) of the Aadhaar number from Aadhaar related data and documents such as proof of possession of Aadhaar, while uploading on CKYCR.
8. Equivalent e-document" means an electronic equivalent of a document, issued by the issuing authority of such document with its valid digital signature including documents issued to the digital locker account of the client as per rule 9 of the Information Technology (Preservation and Retention of Information by Intermediaries Providing Digital Locker Facilities) Rules, 2016.
9. 'Digital KYC process' has to be carried out as stipulated in the PML Rules, 2005.

C 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.

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

1. Provide KYC number of related person, if available.

E Clarification on Minor

1. Guardian details are optional for minors above 10 years of age for opening of bank account only
2. However, in case guardian details are available for minor above 10 years of age, the same (or CKYCR number of guardian) is to be uploaded.

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

State/U.T	Code
Andaman & Nicobar	AN
Andhra Pradesh	AP
ArunachalPradesh	AR
Assam	AS
Bihar	BR
Chandigarh	CH
Chattisgarh	CG
Dadra and Nagar Haveli	DN
Daman & Diu	DD
Delhi	DL
Goa	GA
Gujarat	GJ
Haryana	HR

State / U.T	Code
Himachal Pradesh	HP
Jammu & Kashmir	JK
Jharkhand	JH
Karnataka	KA
Kerala	KL
Lakshadweep	LD
Madhya Pradesh	MP
Maharashtra	MH
Manipur	MN
Meghalaya	ML
Mizoram	MZ
Nagaland	NL
Orissa	OR

State / U.T	Code
Pondicherry	PY
Punjab	PB
Rajasthan	RJ
Sikkim	SK
Tamil Nadu	TN
Telangana	TS
Tripura	TR
Uttar Pradesh	UP
Uttarakhand	UA
West Bengal	WB
Other	XX

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	GO	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	AW	France	FR	Marshall Island	MH	Slovakia	SK
Australia	AU	French Guiana	GF	Martinique	MQ	Slovenia	SI
Austria	AT	French Polynesia	PF	Mauritania	MR	Solomon Island	SB
Azerbaijan	AZ	French Southern Territories	TF	Mauritius	MU	Somalia	SO
Bahamas	BS	Gabon	GA	Moyotte	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	SI
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
Bonaire, Sint Eustatius and Saba	BQ	Guatemala	GT	Nambia	NA	Syrian Arab Republic	SY
Bosnia and Herzegovina	BA	Guernsey	GG	Nauru	MZ	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	Hongkong	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
Cameroon	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 ICote d'Ivoire	CI	Korea, Democratic People's Republic of	KP	Reunion !Reunion	RE	Virgin Island, U.S.	VI
Croatia	HR	Korea, Republic of	KR	Romania	RO	Wallis and Futuna	WF
Cuba	CU	Kuwait	KW	Russian Federation	RU	Western Sahara	EH
Curacao ICuracao	CW	Kyrgyzstan	KG	Rwanda	RW	Yemen	YE
Cyprus	CY	Lao People's Democratic Republic	LA	Saint Barthelemy !Saint BartheJemy	BL	Zambia	ZM
Czech Republic	CZ	Latvia	LV	Saint Helena, Ascension and Tristan da Cunha	SH	Zimbabwe	ZW
Denmark	DK	Lebanon	LB	Saint Kittsand Nevis	KN		
Djibouti	DJ	Lesotho	LS	Saint Lucia	LC		
Dominica	DM	Liberia	LR	Saint Martin (French Part)	MF		