

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



ROYAL SUNDARAM INSURANCE
Sundaram Finance Group

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)

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)

MOST IMPORTANT	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)	
	Mobile No.		WhatsApp No.	
	PLEASE PROVIDE ACTIVE EMAIL ID ONLY AS CLAIMS CORRESPONDENCE WILL BE DONE TO THIS EMAIL ID.			
	Email ID			
	Alternate Email ID			

SECTION A

DETAILS OF INSURANCE HISTORY (MANDATORY)

a) Currently covered by any other Medclaim/Health Insurance	<input type="checkbox"/> Yes <input type="checkbox"/> No
b) If yes, Company Name	
Policy No.	
c) Date of commencement of first Insurance without break	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
d) Sum Insured (Rs.)	
e) Have you been hospitalized in the last four years since inception of the contract?	<input type="checkbox"/> Yes <input type="checkbox"/> No
f) Date	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
g) Diagnosis	

SECTION B

DETAILS OF INSURED PERSON HOSPITALIZED

a) Name							
b) Gender	<input type="checkbox"/> Male <input type="checkbox"/> Female	c) Age	<input type="text"/> <input type="text"/> Years	<input type="text"/> <input type="text"/> Months	d) Date of Birth	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	
e) Relationship to Primary insured	<input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Father <input type="checkbox"/> Mother <input type="checkbox"/> Other (Please Specify)						
f) Communication Address							
City		State					
Pin Code		Land Line (with STD Code)					
g) Occupation	<input type="checkbox"/> Doctor <input type="checkbox"/> Service <input type="checkbox"/> Self Employed <input type="checkbox"/> Homemaker <input type="checkbox"/> Student <input type="checkbox"/> Retired <input type="checkbox"/> Other (Please Specify)						
h) Name of the Employer							
i) Address of the Employer							

SECTION C

DETAILS OF HOSPITALIZATION

a) Name & Address of Hospital where Admitted							
City		State					
Pin Code		Land Mark					
b) Room Category occupied	<input type="checkbox"/> Day care <input type="checkbox"/> Single occupancy <input type="checkbox"/> 3 or more beds per room <input type="checkbox"/> Any other category, Pls specify						
c) Hospitalization due to	<input type="checkbox"/> Injury <input type="checkbox"/> Illness <input type="checkbox"/> Maternity	d) Date of Injury/Date Disease first detected	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>				
e) Date of Admission	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> Time <input type="text"/> <input type="text"/> : <input type="text"/> <input type="text"/>	f) Date of Discharge	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> Time <input type="text"/> <input type="text"/> : <input type="text"/> <input type="text"/>				
g) In case of maternity,	1 Date of Delivery <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	2 Gravida Status					
h) If Injury, give cause	<input type="checkbox"/> Self inflicted <input type="checkbox"/> Road Traffic Accident <input type="checkbox"/> Substance Abuse/Alcohol Consumption						
1. If Medico legal <input type="checkbox"/> Yes <input type="checkbox"/> No		2. Reported to police <input type="checkbox"/> Yes <input type="checkbox"/> No		3. MLC Report & Police FIR attached <input type="checkbox"/> Yes <input type="checkbox"/> No			
i) System of Medicine							

SECTION D

DETAILS OF CLAIM

a) Details of the treatment expenses claimed

1. Pre-hospitalization Expenses	Rs.	<input type="text"/>	2. Hospitalization Expenses	Rs.	<input type="text"/>
3. Post-hospitalization Expenses	Rs.	<input type="text"/>	4. Health-Check up Cost	Rs.	<input type="text"/>
5. Ambulance Charges	Rs.	<input type="text"/>	6. Others	Rs.	<input type="text"/>
			Total amount claimed	Rs.	<input type="text"/>

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.	<input type="text"/>	2. Surgical Cash	Rs.	<input type="text"/>
3. Critical Illness Benefit	Rs.	<input type="text"/>	4. Convalescence	Rs.	<input type="text"/>
5. Pre/Post hospitalization Lump sum benefit:	Rs.	<input type="text"/>	6. Others	Rs.	<input type="text"/>
No of days (Pre Hospitalisation)	<input type="text"/>		Total amount claimed	Rs.	<input type="text"/>
No of days (Post Hospitalisation)	<input type="text"/>				

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

- | | | |
|---|---|--|
| <input type="checkbox"/> Claim Form Duly signed | <input type="checkbox"/> Copy of the claim intimation, if any | <input type="checkbox"/> Original Death Summary (Wherever applicable) |
| <input type="checkbox"/> Advance payment Receipt (Mandatory) | <input type="checkbox"/> Final Bill Payment Receipt (Mandatory) | <input type="checkbox"/> Hospital Main Bill <input type="checkbox"/> Hospital Break-up Bill |
| <input type="checkbox"/> Pharmacy Bill | <input type="checkbox"/> Doctor's request for investigation | <input type="checkbox"/> Hospital Discharge Summary |
| <input type="checkbox"/> Doctor's prescription for medicines purchased outside the hospital and investigation done outside hospital | | <input type="checkbox"/> Investigation Reports (Including CT/MRI/USG/HPE/ECG) |
| <input type="checkbox"/> Cancelled Cheque leaf of the bank account held in the name of the primary insured (Mandatory) | | <input type="checkbox"/> Test report and prescription relating to first consultation for the illness |
| <input type="checkbox"/> CKYC Registration Number of the Proposer (In case already registered for CKYC - enter register numbers): <input type="text"/> | | <input type="checkbox"/> FIR/MLC in case of accident injury and English translation of the same if it is in any other language |
| <input type="checkbox"/> 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) | | |

***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		<input type="checkbox"/> Advance Receipt <input type="checkbox"/> Final Receipt
	D D M M Y Y Y Y		<input type="checkbox"/> Advance Receipt <input type="checkbox"/> Final Receipt
	D D M M Y Y Y Y		<input type="checkbox"/> Advance Receipt <input type="checkbox"/> Final Receipt
	D D M M Y Y Y Y		<input type="checkbox"/> Advance Receipt <input type="checkbox"/> Final Receipt

Note : Please attach separate sheet if necessary

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

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 primary insured / proposer

Royal Sundaram General Insurance Co. Limited

(Formerly known as Royal Sundaram Alliance Insurance Company Limited)

Corporate Office: Vishranthi Melaram Towers, No. 2 / 319, Rajiv Gandhi Salai (OMR), Karapakkam, Chennai - 600097.

IRDAI Registration No.102 | CIN: U67200TN2000PLC045611

1860 425 0000



customer.services@royalsundaram.in



www.royalsundaram.in

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)

DETAILS OF HOSPITAL

a) Name of the hospital	
b) Hospital ID	
(For Office use only)	
c) Type of Hospital	<input type="checkbox"/> Network <input type="checkbox"/> 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 A

DETAILS OF THE PATIENT ADMITTED

a) Name of the Patient:	
b) IP Registration Number	
c) Gender	<input type="checkbox"/> Male <input type="checkbox"/> Female
d) Age	<input type="text"/> Years <input type="text"/> Months
e) Date of Birth	<input type="text"/>
f) Type of Admission	<input type="checkbox"/> Emergency <input type="checkbox"/> Planned <input type="checkbox"/> Day Care <input type="checkbox"/> Maternity
g) Date of Admission	<input type="text"/> Time <input type="text"/>
h) Date of Discharge	<input type="text"/> Time <input type="text"/>
i) If Maternity	
1. Date of Delivery	<input type="text"/>
2. Gravida Status	_____
j) Status at time of discharge	<input type="checkbox"/> Discharge to home <input type="checkbox"/> Discharge to another hospital <input type="checkbox"/> Deceased

SECTION B

DETAILS OF AILMENT DIAGNOSED

	ICD 10 Codes	Description	Duration
1. Primary Diagnosis	<input type="text"/>	_____	<input type="text"/>
2. Additional Diagnosis	<input type="text"/>	_____	<input type="text"/>
3. Co-morbidities	<input type="text"/>	_____	<input type="text"/>
4. Co-morbidities	<input type="text"/>	_____	<input type="text"/>
ICD 10 PCS Codes			
1. Procedure(1)	<input type="text"/>	_____	
2. Procedure(2)	<input type="text"/>	_____	
3. Procedure(3)	<input type="text"/>	_____	
4. Details of any other Procedure	<input type="text"/>	_____	

SECTION C

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
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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 _____

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 _____

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 Co. Limited

(Formerly known as Royal Sundaram Alliance Insurance Company Limited)

Corporate Office: Vishranthi Melaram Towers, No. 2 / 319, Rajiv Gandhi Salai (OMR), Karapakkam, Chennai - 600097.

IRDAI Registration No.102 | CIN: U67200TN2000PLC045611

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🌐 www.royalsundaram.in

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)

Name* (Same as ID proof)

Maiden Name

Father / Spouse Name

Mother Name

Date of Birth* DD - MM - YYYY

Gender* M- Male F- Female T-Transgender

PAN* Form 60 furnished

Prefix	First Name	Middle Name	Last Name
<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"/>

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

District* Pin/Post Code* State/U.T Code* City / Town / Village* 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

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

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 Pol does not have current address or address as per Pol 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	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
Gujarat	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	LJ	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	Swalbard 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	NZ	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 IReunion	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 ISaint 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		