ICICI Lombard Health Insurance

Comprehensive Health Insurance Proposal Form

To be filled in by the proposer

Please ensure that the details furnished in the proposal form are correct and complete in all respects. The company's decision for acceptance of the risk will be on the basis of information provided below. In case of any doubt regarding the information to be provided, please seek advice from your insurance advisor or agent. Please attach additional sheets if required. The policy issued under this plan will be valid for one / two years (auto-renewal basis) as applicable.

Proposer's information Source Code ____________________ Proposal Number CHI ____________________

Proposer's name (please leave a space after each part of name)

Mr. / Ms. / Dr.

FIRST MIDDLE LAST

Date of Birth: __ __ / __ __ / __ __ __ __

Proposer mailing address

Room No./Block No./House No.: ____________________

Building Name/Wing/Plot/Sector No./ Floor No.: ____________________

Road No./Street Name: ____________________

Land Mark: ____________________ City/Town: ____________________

State: ____________________ Pin code# ______ Sex ☐ M ☐ F

Marital Status ☐ Married ☐ Unmarried

Telephone Number (with STD Code) ____________________ *Mobile Number ____________________

Fax Number ____________________ *E-mail address ____________________

* Kindly provide the details to enable us to serve you better

Name of Family Doctor ____________________

Telephone Number (with STD Code) ____________________ Mobile Number ____________________

Details of persons to be Insured

S. No.	Name in Full	Sex M / F	Date of Birth	Relationship with Applicant	Plan Opted	Name of Pre-existing illness/surgery/symptom	Suffering From (MM / YY)
1.				Self			
2.							
3.							
4.							
5.							
6.							

Sr. No.	Pre-existing Illness/Surgery/Symptoms
1	Smoke/Consume Tobacco
2	Abnormal Blood Pressure/ Cholesterol
3	Diabetes
4	Asthma
5	Spondylosis/back ache/Arthritis
6	Gynecological Disorders
7	Birth Defects/Congenital Problems
8	Hepatitis/Liver disease
9	Mental/Psychiatric disorders
10	Heart Disease
11	Cancer/Tumor
12	Disorders of Brain or Nervous system
13	Kidney and Urinary Tract disorders
14	AIDS/HIV
15	Blood disorders
16	Any illness
17	Any other disease/surgery/symptoms (pls specify)

Note: In case any of the above named persons are currently suffering from any illness / symptom/ injury or have suffered any of the illness/injury/symptom for last 10 years please give complete details about the same. Please use additional sheets if space is not sufficient to give complete details.

☐ Yes! I would like to apply for 1 year cover. Please select the premium amount as applicable for the respective sum insured chosen.

	A		B		C		D	
Age of Senior Most Member	Individual 2L	Individual 3L	2 Adults 3L	2 Adults 4L	2 Adults + 1 Kid 3 L	2 Adults + 1 Kid 4L	2 Adults + 2 Kids 3 L	2 Adults + 2 Kids 4L
5 yrs. - 18 yrs.	2,054	2,364						
19 yrs. - 35 yrs.	2,777	3,200	4,800	7,199	6,217	9,346	7,635	11,493
36 yrs. - 45 yrs.	3,478	3,864	5,796	8,089	7,214	10,236	8,632	12,383
*46 yrs. - 55 yrs.	6,193	6,881	11,009	15,412	12,427	17,559	13,845	19,705
#56 yrs. - 60 yrs.	7,586	8,429	13,486	18,879	14,904	21,026	16,322	23,173

(All prices are inclusive of Service Tax, Education Cess.)

☐ Yes! I would like to apply for 2 year cover. (auto-renewal basis) Please select the premium amount as applicable for the respective sum insured chosen.

	E		F		G		H	
Age of Senior Most Member	Individual 2L	Individual 3L	2 Adults 3L	2 Adults 4L	2 Adults + 1 Kid 3 L	2 Adults + 1 Kid 4L	2 Adults + 2 Kids 3 L	2 Adults + 2 Kids 4L
5 yrs. - 18 yrs.	3,697	4,255						
19 yrs. - 35 yrs.	4,998	5,759	8,640	12,958	11,191	16,822	13,743	20,686
36 yrs. - 45 yrs.	6,261	6,956	10,433	14,560	12,986	18,424	15,538	22,289
*46 yrs. - 55 yrs.	11,766	13,074	20,917	29,282	23,612	33,361	26,306	37,440
#56 yrs. - 60 yrs.	15,172	16,858	26,972	37,758	29,808	42,052	32,644	46,346

(All prices are inclusive of Service tax, Education cess.)

*** / # Medical reports required**

Please select the age of the senior most member as on last birthday. In case of individual plan, please select the age of the individual to be covered as on last birthday. e.g. If your family comprises of you (aged 35 Years & 11 Months), your wife and one kid and you opt for a Rs. 4 lac cover for 2 year the plan applicable will be 2Adults + 1 Kid plan i.e. Plan- G, for the age group of 19-35 years, for 2 year. So, the premium amount will be Rs.16,822. All figures in Rupees. Children between the age of 3 months to 5 years will be covered only under a floater plan.

***Key Exclusion (self inflicted injury)**

- Pregnancy
- Congenital disease
- HIV/AIDS

* This is only an indicative list. For complete list refer to policy wording

Payment Details

☐ Cheque / DD Cheque / DD Number |__|__|__|__|__|__|__|__|__|__| Date : |D|D| / |M|M| / |Y|Y|Y|Y|

Bank _____ Branch _____

Please provide the policy number(s)/proposal form no./Proposal Date in case any of the above proposed individuals are already covered or have been declined a cover or their name(s) have been proposed for any other health insurance policy with ICICI Lombard General Insurance Company or any other Insurance Company.
Policy No/Proposal Form No./ Proposal date:_____

Terms of Renewal

a. The policy can be renewed under the then prevailing Comprehensive Health Insurance Product or its nearest substitute approved by IRDA.
b. Renewal Premium - Premium payable on renewal and on subsequent continuation of cover are subject to change with prior approval from IRDA
c. Maximum Entry Age – The maximum entry age under this policy is 60 years.
d. Maximum Renewal Age – This policy can be renewed up to a maximum age of 70years.
e. Floater Benefit – The floater benefit under this policy is available up to the age of 60 years. If an insured crosses the age of 60 years in a floater plan such insured will be renewed under as individual plan

Declaration

I/ We have read and understood the terms and conditions of the Policy and confirm to abide by the same.

I/We hereby agree that the insurance coverage under the Policy will commence only on realization of full premium, receipt of complete medical reports (wherever applicable) and subject to medical underwriting approval by the Company. Receipt of proposal form by the Company shall not be construed as acceptance of proposal. Company in its sole discretion reserves the right to accept or reject any proposal without assigning any reasons thereof. I/We hereby declare that I/We will submit to medical examinations by the nominated doctors of the Company or undergo diagnostic or other medical tests, as suggested by the Company for its medical underwriting.

I/We hereby declare that the Company reserves the right to enquire from any physicians, nurse, hospital official or employee or any person, institution for all or any information regarding the medical history of the proposed and that the Company shall have the right to ask the proposed for the medical check-up.

I/We, the undersigned hereby declare that the above statements and particulars are true, accurate and complete and I/We declare and agree that this declaration and the answers given above shall be held to be promissory and shall be the basis of the contract between me/us and the Insurer.

I/We authorize the Company and their agents to exchange, share or part with all the information relating to my/ our personal and financial details with Government bodies / Regulatory Authorities/ Statutory bodies, or under court orders as may be required and I/ we will not hold the Company and its agents liable for use of this information.

I/we agree that the Policy shall become voidable at the option of the Insurer, in the event of any untrue or incorrect statement, misrepresentation, non-description or non-disclosure in any material particular in the Proposal form/personal statement, declaration and connected documents, or any material information has been withheld by me/us or anyone acting on my/our behalf to obtain any benefit under this policy.

Name _____ Place _____

Signature of the Proposer_____ Date _____

Important Notes

- The information that you give to us on this proposal form or in any supplementary Information for or documentation supplied by you or on your behalf will influence our decision to offer insurance and the terms upon which to offer it. Further, any policy we issue will be based on what you have communicated to us. It is therefore important that your answer are complete and accurate in all respect.
- The question in this proposal are indicative rather then exhaustive. You must provide us with all information relevant to the risk to be insured, even if it is not the subject of a question in this proposal. If you are in any doubt as to what information should be given, you should liaise with your insurance advisor/ company.
- Acceptance of your proposal would be subject to receipt of complete medical reports(wherever applicable), medical underwriting and realization of full premium amount by the company and the insurance coverage will commence from the date of underwriting by the company.
- The list of exclusions/ inclusions and other policy details are indicative, for complete list and comprehensive details kindly refer policy wordings.

Statutory Warning

PROHIBITION OF REBATES
(Under Section 41 of Insurance Act 1938)

1) No person shall allow or offer to allow, either directly or indirectly as an inducement to any person to take out or renew or continue an insurance in respect of any kind of risk relating to lives or property, in India, any rebate of the whole or part of the commission payable or any rebate of the premium shown on the policy, nor shall any person taking out or renewing or continuing a Policy accept any rebate, except such rebate as may be allowed in accordance with the published prospectuses or tables of the Insurer.
2) Any person making default in complying with the provisions of this section shall be punishable with fine, which may extend to five hundred rupees.

ICICI Lombard General Insurance Co. Ltd. Insurance is the subject matter of the solicitation. Misc 34E.

For Office use only

OPS Code : _____

Channel Code :_____

Channel Name : _____

Location : _____

Check List

Please ensure that
1. You have filled the details of your family members to be insured
2. You have signed the declaration
3. You have declared pre-existing illnesses (if applicable)
4. Please fill up the proposal form and provide all the detail/information sought herein above. Kindly strike out the Portions which are not relevant to you or any of the prospects proposed herein above.

For Retail Telesales

SM name:_____

TSO name:_____ TSO id:_____

SO name: _____ SO id:_____

Location name:_____ Location code:_____

ICICI Lombard
Health Insurance