ICICI Lombard
Nibhaye Vaade

# Group TakeCare Insurance - Proposal Form

**FOR OFFICE USE ONLY**

URN No.: 36020171850011500 2/01 Code/Functional Identity:

Intermediary Name / Principal Officer Name:

MO EMP ID Sector: Urban Rural Social

## GUIDELINES FOR COMPLETION OF THE FORM (To be filled by the Proposer/Group Administrator)

1. Please answer all the questions fully and correctly. Where any question does not apply, please mention clearly that the same is not applicable.
2. Insurance is a contract of utmost good faith requiring the proposer to disclose all material facts in response to the questions in the proposal form. This obligation continues until the policy is expired and does not end with the submission of this proposal form. If therefore, there is any change in the information given herein or new information comes to light before the policy expires, then you must inform us of the same in writing without delay.
3. The Policy shall become void at the option of the insurer, in the event of any untrue or incorrect statement, misrepresentation, non-description or nondisclosure of any material fact, particularly in the proposal form/personal statement, declaration and connected documents or any material information having been withheld by the proposer or anyone acting on his behalf.
4. Kindly contact Our offices or Agents for any doubts or clarifications on the proposal form.

Note: Our liability does not commence until the premium is duly received and proposal has been accepted by Us.

## CUSTOMER INFORMATION - PART A

The application form is to be filled in CAPITAL LETTERS by the Proposer/Group Administrator. Please answer all questions fully and correctly. Where any question does not apply, please mention clearly the question is not applicable

Name of the Proposer/Group Administrator (organization/institute/association):

Permanent Address of Proposer/Group Administrator:

Landmark:

City/Town: State: Pin Code:

Mailing Address of Proposer/Group Administrator:

Landmark:

City/Town: State: Pin Code:

Nature of Group: Employer-Employee Employer-Employee

Mobile Number*: E-mail ID:

GSTIN No.: Pan No.:

CKYC/Driving License/Aadhaar/Election Card/Passport/MNREGA Card No.:

Date of Incorporation: D D M M Y Y Y Y

Place of Incorporation:

Registration No. (E.g. CIN)

Status (please tick any one)

Private Limited Co. Public Ltd. Co. Unincorporated Association or Body of Individuals Partnership/LLP

Trust/ Foundation Government NGO/NPO (If yes, obtain DARPAN Portal Registration No.)

Others (please specify)

Nature of Business:

ABHA No ☐☐☐☐☐☐☐☐☐☐☐☐☐☐

I agree to share my medical records with ICICI Lombard / TPA through ABHA: ☐ Yes ☐ No

For generating ABHA no please visit ABHA number (ndhm.gov.in) Post generation of the ABHA no please share the same with us

Are you or any of the proposed applicants/beneficial owner a PEP* or Family member/ Close relatives/Associates of PEPs*?

☐ Yes ☐ No

If yes, please give details (Nature of relationship and position held by PEP):_____

*Politically Exposed Persons" (PEPs) are individuals who have been entrusted with prominent public functions by a foreign country, including the heads of States or Governments, senior politicians, senior government or judicial or military officers, senior executives of state-owned corporations and important political party officials, etc.*

Details of Beneficial Owner*

Mention the details of individual persons who has/have the Beneficial Ownership in the captioned entity:

| Sr. No. | Full Name | Date of Birth | Nationality | Address | % Share Holding | PAN | **Politically Exposed Person(PED) Declaration |
|---|---|---|---|---|---|---|---|
| | | | | | | | ☐ PEP<br>☐ Family member/ Close relatives /Associates to PEP<br>☐ No |
| | | | | | | | ☐ PEP<br>☐ Family member/ Close relatives /Associates to PEP<br>☐ No |
| | | | | | | | ☐ PEP<br>☐ Family member/ Close relatives /Associates to PEP<br>☐ No |
| | | | | | | | ☐ PEP<br>☐ Family member/ Close relatives /Associates to PEP<br>☐ No |

Important note:-

(*) The beneficial owner shall be determined as follows:

(a) where the client is a company, the beneficial owner is the natural person(s), who, whether acting alone or together, or through one or more juridical person, has a controlling ownership interest (more than ten percent of shares or capital or profits of the company) or who exercises control through other means

(b) where the client is a partnership firm, the beneficial owner is the natural person(s), who, whether acting alone or together, or through one or more juridical person, has ownership of/entitlement to more than ten percent of capital or profits of the partnership or who exercises control through other means

"Explanation - For the purpose of this clause, "Control" shall include the right to control the management or policy decision;"

(c) where the client is an unincorporated association or body of individuals, the beneficial owner is the natural person(s), who, whether acting alone or together, or through one or more juridical person, has ownership of or entitlement to more than fifteen percent of the property or capital or profits of such association or body of individuals

(d) where the client is a trust, the identification of beneficial owner(s) shall include identification of the author of the trust, the trustee, the beneficiaries with ten percent or more interest in the trust and any other natural person exercising ultimate effective control over the trust through a chain of control or ownership

(e) where no natural person is identified under (a) or (b) or (c) above, the beneficial owner is the relevant natural person who holds the position of senior managing official

## NOMINEE/APPOINTEE SECTION

| | 1st Nominee | 2nd Nominee | 3rd Nominee | 4th Nominee | 5th Nominee |
|---|---|---|---|---|---|
| Name of Nominee | | | | | |
| Relation with Insured | | | | | |
| Date of Birth | | | | | |
| Percentage of Nomination | _____% | _____% | _____% | _____% | _____% |
| Gender | | | | | |
| Mailing Address | | | | | |
| | | | | | |
| Permanent Address | | | | | |
| | | | | | |
| Mobile Number | | | | | |
| Email ID | | | | | |

## DETAILS OF APPOINTEE (Details to be filled only if nominee is a minor)

Appointee Name: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ Relationship with Proposer: ☐☐☐☐☐☐☐☐

## INSURED DETAILS - PART B

Period of Insurance: From D D M M Y Y Y Y To D D M M Y Y Y Y

Policy tenure: Year(s) ☐☐☐☐☐ / Month(s) ☐☐ / Day(s) ☐☐ / Hour(s) ☐☐

Type: New ☐ Renewal ☐ (In case of renewal, please mention previous policy no. ( _____ )

Expected number of persons to be insured in the group: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Tentative Age Mix and SI mix of prospective group: ☐☐

| Age (in years) | Percentage distribution |
|---|---|
| 18-25 | |
| 26-40 | |
| 41-50 | |
| 51-65 | |
| >65 | |

Please provide the list of persons to be insured in the following format:

| Name of the employee / self and dependant | Relation with the employee / self | Date of Birth | Age | Gender | Email | Occupation | Income per annum | ABHA No. | Mobile No. | Sum Insured (₹) | Specify existing diseases, if any |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | | | |
| | | | | | | | | | | | |
| | | | | | | | | | | | |

Do you agree to share your medical records with ICICI Lombard GIC Ltd / TPA through ABHA : ☐ Yes ☐ No

For generating ABHA no please visit ABHA number (ndhm.gov.in) Post generation of the ABHA no please share the same with us

Note:

1) Please attach a separate sheet if space available is not sufficient for filling in complete details.
2) Names of the dependants should be mentioned immediately below the name of each employee

Do all the members proposed to be insured form part of One Group or Association or Corporate Body? ☐ Yes ☐ No

## SCOPE OF COVER - PART C

The Policy offers coverage against multiple health risks by providing hospital daily cash cover, outpatient cover and wellness covers, as opted by the proposer. For complete details on coverage, please refer to the Policy wordings.

## TABLE OF BENEFITS - PART D

The Policy offers coverage against multiple health risks by providing hospital daily cash cover, outpatient cover and wellness covers, as opted by the proposer. For complete details on coverage, please refer to the Policy wordings.

| Section and Benefits | Base/Extension | ✓for availing coverage | Additional Details |
|---|---|---|---|
| **SECTION A: Hospifund Benefit** | | | |
| Daily Amount : ₹ ☐☐☐☐☐☐☐☐☐☐☐☐☐☐ | | Benefit Period: D D M M Y Y Y Y | |
| Subsection A.1: Base Benefits (Choose at least one) | | | |
| Hospitalization Cash Benefit | Base | ☐ | ☐ Deductible ☐ Franchise ☐☐ Days |
| Accidental Hospitalization Cash Benefit | Base | ☐ | ☐ Deductible ☐ Franchise ☐☐ Days |
| Accidental Hospitalization Cash Benefit | Base | ☐ | ☐ Deductible ☐ Franchise ☐☐ Days |
| Subsection A.2 : Extensions to the Base Benefits | | | |
| Intensive Care Cash Benefit | Extension | ☐ | ☐ Deductible ☐ Franchise ☐☐ Days |
| Cancer Hospitalization Cash Benefit | Extension | ☐ | ☐ Deductible ☐ Franchise ☐☐ Days |
| Brain & Stroke Hospitalization Cash Benefit | Extension | ☐ | ☐ Deductible ☐ Franchise ☐☐ Days |
| Organ Transplant Hospitalization Cash Benefit | Extension | ☐ | ☐ Deductible ☐ Franchise ☐☐ Days |
| Heart Ailment Hospitalization Cash Benefit | Extension | ☐ | ☐ Deductible ☐ Franchise ☐☐ Days |
| Fracture & Burns Cash Benefit | Extension | ☐ | ☐ Deductible ☐ Franchise ☐☐ Days |
| Day Care Treatment Cash Benefit | Extension | ☐ | N.A. |
| Convalescence Benefit | Extension | ☐ | N.A. |
| Ambulance Cover Benefit | Extension | ☐ | ☐ Deductible ☐ Franchise ☐☐ Days |
| Child Care Cash Benefit | Extension | ☐ | ☐ Deductible ☐ Franchise ☐☐ Days |
| Hospital Attendant Cash Benefit | Extension | ☐ | N.A. |
| Compassionate Visit Cash Benefit | Extension | ☐ | N.A. |
| **Base Benefit: Outpatient Cover** | | | |
| **Sum Insured : ₹** Do you wish to avail policy documents in physical form: Yes ☐ No ☐ | | | ☐ Sub - limit ☐ Co-Pay |
| **Cover(s) under Outpatient Cover** | | | |
| Consultation Cover | | | ☐ Sub - limit Remarks _____ |
| Pharmacy Cover | | | ☐ Sub - limit Remarks _____ |
| Diagnostic Cover | | | ☐ Sub - limit Remarks _____ |
| Minor Procedures | | | ☐ Sub - limit Remarks _____ |
| Travel Expenses for Medical Treatment | | | ☐ Sub - limit Remarks _____ |
| Section C: Wellness Cover (Optional Section) | | | |
| Routine Physical & Preventive Examinations | Extension | ☐ | |
| Onsite Health Services | Extension | ☐ | |
| Wellness Session | Extension | ☐ | |
| Health Risk Assessment (HRA) | Extension | ☐ | |
| Wellness Event | Extension | ☐ | |
| Telephonic /Virtual Consultation | Extension | ☐ | |
| Workplace Wellness Management Program | Extension | ☐ | |
| Emergency Ambulance Service | Extension | ☐ | |
| Any additional information relevant to coverage(s) in the policy _____ | | | |
| Do you wish to avail policy documents in physical form: Yes ☐ No ☐ | | | |

## PREMIUM DETAILS - PART E

(Applicable for non-contributory policy)

Premium Amount: ₹ ☐☐☐☐☐☐☐☐☐☐ DD /Cheque Amount: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Amount: ₹ ☐☐☐☐☐☐☐☐☐☐☐ DD/Cheque No. ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

In case of NEFT please specify NEFT details: Issuing Bank Name: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Bank Name: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Premium Payment Frequency: Lumpsum ☐ Yearly ☐ Half-Yearly ☐ Monthly ☐

Branch Name ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ Account Holder Name ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

IFSC Code ☐☐☐☐☐☐☐☐☐☐☐ Account Number ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

## BANK ACCOUNT DETAILS

For direct payment of claims/ refunds in the account, please fill the following:

Bank ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ Branch ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

MICR ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ IFSC* ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Account Number: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Account Type: ☐ Savings ☐ Current ☐ Cash Credit ☐ Overdraft

*Please enclose cancelled cheque along with the enrollment Form for direct payment in the account. In case the cheque doesn't bear a/c holder name or branch IFSC code or both, kindly fill the NEFT mandate form

## NOMINEE BANK ACCOUNT DETAILS

For direct payment of claims/ refunds in the account, please fill the following:

Bank ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ Branch ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

MICR ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ IFSC* ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Account Number: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Account Type: ☐ Savings ☐ Current ☐ Cash Credit ☐ Overdraft

*Please enclose cancelled cheque along with the enrollment Form for direct payment in the account. In case the cheque doesn't bear a/c holder name or branch IFSC code or both, kindly fill the NEFT mandate form

Please mention if you have lodged any claim in the past under Group TakeCare Insurance with us or any similar policy with us or any other insurer in the past. If yes, please provide details of last 3 policies:

| Policy Period (From and To) | Name & Address of the Insurer | Policy Number | Premium paid | Total claim amount (₹) | Claim Details |
|---|---|---|---|---|---|
| From D D M M Y Y Y Y<br>To D D M M Y Y Y Y | | | | | |
| From D D M M Y Y Y Y<br>To D D M M Y Y Y Y | | | | | |
| From D D M M Y Y Y Y<br>To D D M M Y Y Y Y | | | | | |

Note: Please attach a separate sheet if space available is not sufficient for filling in complete details. Any additional information material to assumption of risk

## DECLARATION

1. I hereby declare, on my behalf and on behalf of all persons proposed to be insured, that the above statements, answers and/or particulars given by me are true and complete in all respects to the best of my knowledge and that I am authorised to propose on behalf of these other persons.
2. I understand that the information provided by me will form the basis of the insurance policy, is subject to the Board approved underwriting policy of the insurer and that the policy will come into force only after full payment of the premium chargeable.
3. I further declare that I will notify in writing any change occurring in the occupation or general health of the life to be insured/proposer after the proposal has been submitted but before communication of the risk acceptance by the company.
4. I declare that I consent to the company seeking medical information from any doctor or hospital who/which at any time has attended on the person to be insured/proposer or from any past or present employer concerning anything which affects the physical or mental health of the person to be insured/proposer and seeking information from any insurer to whom an application for insurance on the person to be insured /proposer has been made for the purpose of underwriting the proposal and/or claim settlement.
5. I authorize the company to share information pertaining to my proposal including the medical records of the insured/proposer for the sole purpose of underwriting the proposal and/or claims settlement and with any Governmental and/or Regulatory authority.

Additional Declarations:

6. I have been provided with the detailed terms of the policy. I have read, understood and am aware of the detailed terms of the policy.
7. I declare that the contents of this proposal form and other documents have been fully explained to me and I have fully understood the significance of the proposed contract.
8. I hereby give consent for receiving proposal form and policy copy in electronic form only. The provision for physical copy of the proposal form would be as per the relevant IRDA guidelines.
9. I hereby confirm that I have insurable interest in the policy and the premium is not borne by any third party entity or person.
10. I/We hereby give my/our consent to the Company to verify and obtain my/our identity/address proof as well as the identity /address proof of the insured through Central KYC Registry or UIDAI or through any other modes for the purpose of undertaking KYC.
11. I/We hereby declare and confirm that the premium has been paid out of legally acquired sources of income and the subsequent premiums if any will continue to be paid out of legally declared and assessed source of income.
12. I/We understand that the Company has right to call for documents to establish source of funds.
13. I/We hereby declare that the details furnished above are true and correct to the best of my/our knowledge and belief and I/we undertake to inform you of any changes therein, immediately and not later than 30 days.
14. In case any of the above information is found to be false or untrue or misleading or misrepresenting, I/We am/are aware that I/We may be held liable for it.

    Further, the Company has a right to cancel the insurance contract in case, I am/have been found guilty by any competent court of law under any statutes, directly or indirectly governing the prevention of money laundering.
15. I/We hereby agree and ensure to maintain details of all the beneficiaries covered under the policy and shall share the same with Company as and when required.

Name

Date D D M M Y Y Y Y Place

Designation

Proposer's Signature

## STATUTORY WARNING PROHIBITION OF REBATES

**Section 41 of Insurance Act, 1938**
**(Amendment Act 2015)**

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:

   [Provided that acceptance by an insurance agent of commission in connection with a policy of any class of insurance business taken out by himself in relation to risks associated with his own life, health or property shall not be deemed to be acceptance of a rebate of premium within the meaning of this sub-section if at the time of such acceptance the insurance agent satisfies the prescribed conditions establishing that he is a bona fide insurance agent employed by the insurer.]

2) Any person making default in complying with the provisions of this section shall be liable for a penalty which may extend to ten lakh rupees.]

## DECLARATION WHEN THE ENROLLMENT FORM IS FILLED BY A PERSON OTHER THAN THE PROPOSER/ THE PROPOSER SIGNS IN A VERNACULAR LANGUAGE/PROPOSER IS ILLITERATE OR DISABLED

I hereby declare that I have read out and explained the content of this enrollment form and all other connected documents incidental to availing the insurance policy from ICICI Lombard GIC Ltd. to the proposer and that he/ she confirmed that he/ she has understood the same and that he/ she agrees to abide by all the terms & conditions of the same.

I hereby declare that I have fully explained to the proposer the answers to the questions that form the basis of the contract of insurance have also explained the contents in this form to the proposer in _____ language, that I have truly and correctly recorded the answers give by the proposer and that the proposer has affixed his/ her thumb impression on the enrollment form in my presence, after fully understanding the contents thereof. Further, this declaration does not confirm issuance of policy or assumption of risk thereof.

I hereby state that the contents of the form and documents have been fully explained to me and that I have fully understood the significance of the proposed contract.

Name of Proposer: _____ Name of Witness: _____

Signature of Proposer: _____ Signature of Witness: _____

Date: D D / M M / Y Y Y Y Place: _____

Relationship with Proposer: _____

Address of Witness: _____

_____

_____

## INTERMEDIARY DECLARATION AND DETAILS/PRINCIPAL OFFICER DETAILS

I, _____(Name)_____<full name> in my capacity as an Insurance Advisor/ Specified Person of the Corporate Agent/ Insurance Sales Persons of Insurance Marketing Firm / Broker Qualified Person/ Point of Sales Person/ Designated Person/ Authorised Verifier or any other authorised salesperson/ Rural Authorized Person (RAP) and Village Level Entrepreneur – Ins (VLE-Ins) of Common Public Service Centre do hereby declare that I have explained all the contents of this Proposal Form, including the nature of the questions contained in this Proposal Form to the Proposer including statement(s), information and response(s) submitted by him/her in this Proposal Form to questions contained herein or any details sought herein will form the basis of the Contract of Insurance between the Company and the Proposer, if this Proposal is accepted by the Company for issuance of the Policy. I have further explained that if any untrue statement(s)/ information/response(s) is/are contained in this Proposal Form/including addendum(s), affidavits, statements, submissions, furnished/to be furnished, the Company shall have the right to cancel the policy at its discretion. Further, this declaration does not confirm issuance of policy or assumption of risk thereof.

_____ (to be filled in, only in case there is some disclosure to be made).

I hereby confirm to the best of my knowledge and belief that there is no inconsistency or adverse habits that may affect the underwriting of this proposal except as mentioned below:

Intermediary Name / Principal Officer Name: _____

Code/Functional Identity: _____ Contact No. of the branch: _____

Email ID of the branch: _____

Branch/Office: _____