ICICI Lombard Nibhaye Vaade

ACTIVATE BOOSTER PROPOSAL FORM

UIN: ICIHLIP25046V012425

For Official Use Only

Product Code:
Intermediary ID :
Branch Name :
Proposal No. :
Intermediary Name :
Deal No. :

GUIDELINES FOR COMPLETION OF THE FORM (To be filled by proposer)

Please answer all the questions fully and correctly. Where any question does not apply, please mention clearly that the same is not applicable.

Insurance is a contract of Utmost Good Faith requiring the Insured not only to disclose all material facts but also not to suppress any material facts in response to the questions in the proposal form. Please disclose all material facts while filing in the proposal form.

The Policy shall become void at the option of 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 having been withheld by the Proposer or any one acting on his behalf. Kindly contact the Company's Offices or Agents for any doubts or clarifications on the proposal form.

PROPOSER / CUSTOMER INFORMATION

Please fill all the particulars in CAPITAL letters only

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

Mr. / Ms. / Dr. : F I R S T M I D D L E L A S T

Date of Birth : D D / M M / Y Y Y Y Gender : Male ☐ Female ☐ Third gender ☐

GST Number: (If Applicable) Occupation details: Salaried ☐ Self employed ☐ Business ☐ Others ☐

PAN Card No.: CKYC No.

Correspondence Address :

Landmark :

City : State : Pin code :

Landline No. (with STD Code) : Mob. No*: Whatsapp Mob. No*

E-mail address :

Permanent Residence Address :

Landmark :

City : State : Pin code :

Are you or any of the proposed applicants a PEP* or Family member/ Close relatives/Associates of PEPs*? Y ☐ N ☐

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;

I agree to receive policy copy and important information about my policy via Whatsapp on this number Y ☐ N ☐

Do you wish to avail policy documents in physical form Y ☐ N ☐

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

NOMINEE DETAILS

	1st Nominee	2nd Nominee	3rd Nominee	4th Nominee
Name of Nominee				
Date of Birth of Nominee	DD/MM/YYYY	DD/MM/YYYY	DD/MM/YYYY	DD/MM/YYYY
Percentage of Nomination	_____%	_____%	_____%	_____%
Relation of the Nominee with the Insured				
Mobile No				
Email ID				
Present Address				
Permanent Address				

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

Appointee Name Relationship with Proposer :

DETAILS OF PERSONS TO BE INSURED

Insured No.	Full Name (First, Middle, Last)	Gender (M/F/T)	Date of Birth (DD/MM/YY)	Age	Relationship with Proposer	Height (feet/inch)	Weight (kgs)	Income per annum	ABHA No.	Occupation	PAN No.
1.			D D / M M / Y Y								
2.											
3.											
4.											
5.											

Are all insured Indian nationals and Indian residents? Yes ☐ No ☐ If Not, please provide details: _____

ABHA No. _____ (In case you do not have ABHA No. please generate your ABHA No. by visiting the official website ndhm.gov.in and fill the details hereinabove)

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

DETAILS OF OTHER HEALTH INSURANCE POLICIES TILL DATE

Product Name	Policy No. / Proposal No.	Period of Insurance	Sum Insured	Claims lodged during policy period (Yes/No)

DETAILS OF THE INSURANCE PRODUCT/ PLANS

Please fill the form as per your health care needs.

Tenure

☐ 1 Year ☐ 2 Years ☐ 3 Years* *In case the insured person in the policy is a surrogate mother, policy tenure of 3 years will be mandatory.

Plan

☐ Plan A ☐ Plan B

Policy Type

☐ Individual ☐ Floater

Sum Insured

☐ 10 Lakhs ☐ 15 Lakhs ☐ 20 Lakhs ☐ 25 Lakhs ☐ 45 Lakhs ☐ 50 Lakhs ☐ 85 Lakhs ☐ 90, Lakhs ☐ 95 Lakhs ☐ 1 Crore ☐ 3 Crore ☐ 4.9 Crore ☐ Unlimited

Deductible Opted

☐ 3 Lakhs ☐ 4 Lakhs ☐ 5 Lakhs ☐ 7.5 Lakhs ☐ 10 Lakhs, ☐ 15 Lakhs ☐ 20 Lakhs

Zone

☐ **Zone A :** Delhi, Mumbai (including Thane district, Navi Mumbai) , Gurugram district, Karnal district, Sonipat district, Rohtak district, Bhiwani district, Chakri Dadri district, Mahendragarh district, Daman & Diu, Dadra Nagar, Ahmedabad, Surat, Noida City, Ghaziabad district, Hapur district, Meerut district, Muzaffarnagar district, Shamali district

☐ **Zone B :** Pune, Kolkata, Telangana (incl. Hyderabad), Madhya Pradesh, Goa, Gujarat (excl. Ahmedabad and Surat), Bangalore, Chennai, Andhra Pradesh, Chattisgarh, Pondicherry, Uttarakand

☐ **Zone C** : Rest of India (Punjab, Rajasthan (excl. NCR region), Chandigarh, Himachal Pradesh, Jammu & Kashmir, Ladakh, Lakshadweep, Kerala, Tamil Nadu (excl. Chennai, Pondicherry), Odisha, Arunachal Pradesh, Assam, Manipur, Meghalaya, Mizoram, Nagaland, Tripura, Sikkim, Andaman & Nicobar, Rest of Karnataka, West Bengal (excl. Kolkata), Bihar, Jharkhand, Maharashtra (excl. Mumbai and Pune), UP (excl. NCR Region), Haryana (excl. NCR region)

☐ **Zone D :** Rest of NCR[Alwar district, Bagpat district, Bharatpur district, Bulandshahr district, Faridabad district, Gautam Buddha Nagar district excl. Noida, Jhajjar district, Jind district, Nuh district, Panipat district, Rewari district, Mewat district, Palwal district]

Optional Benefits

1	JumpStart	☐ YES	☐ NO	10	Dependent accommodation benefit*	☐ YES	☐ NO
2	Chronic Disease Management Program	☐ YES	☐ NO	11	Durable medical equipment	☐ YES	☐ NO
3	BeFit**	☐ YES	☐ NO	12	Teleconsultations	☐ YES	☐ NO
4	Claim Protector	☐ YES	☐ NO	13	Waiting period reduction option	☐ YES	☐ NO
5	Inflation Protector	☐ YES	☐ NO	14	Specific illness waiting period	☐ YES	☐ NO
6	Domestic Air Ambulance	☐ YES	☐ NO	15	Room modifier	☐ YES	☐ NO
7	Nursing at home*	☐ YES	☐ NO	16	Network advantage	☐ YES	☐ NO
8	Compassionate*	☐ YES	☐ NO	17	NRI Advantage - Accidental Emergencies Cover for NRI	☐ YES	☐ NO
9	Health Check-up*	☐ YES	☐ NO	18	Guaranteed Deductible Reduction	☐ Yes	☐ No

Important Points

a. Jumpstart Optional Cover will have to be opted for a period of 3 continuous policy years.
b. Chronic Disease Management Program will be available only if Jumpstart is opted. The Health check ups under Chronic Disease Management Program are over and above to the Health check up if opted.
c. Waiting Period Reduction Option will have to be opted for a period of 3 continuous policy years.
d. Specific Illness Waiting Period Reduction will have to be opted for a period of 2 continuous policy years.
Claims under Accidental Emergencies cover for NRI will be paid for Accidental Emergencies only within geographical boundaries of India. No claim will be admissible under any other cover of this policy. All waiting periods as per the policy terms and conditions will be applicable.
e. (*) Cover applicable only in Plan B (**) Befit Waiting Period is 30 Days

waiting period with options (If Opted)

1. Waiting period reduction option ☐ 12 Months ☐ 24 Months
2. Specific illness waiting period reduction option ☐ 12 Months

Room Modifier (If Opted)

☐ Any room rent category
☐ Twin sharing room only
☐ 1% of Annual Sum Insured for normal room and 2% of Annual Sum Insured for ICU per day

Medical Underwriting Required for person aged 46 years and above and/ or for Sum Insured option above 10 lacs (above are subject to modifications).
Cost of Pre Policy Medical Check-up for policy issuance: Atleast 50% of the pre policy medical test cost will be paid by the Company. In case the health proposal is declined, medical cost will be deducted from the premium and the balance would be refunded.

PAYMENT DETAILS

Payment Option: Cheque ☐ DD ☐ NEFT ☐ UPI ☐ Dated: D D / M M / Y Y Y Y

Cheque ☐ DD Number ☐☐☐☐☐☐☐☐☐☐ NEFT ☐☐☐☐☐☐☐☐☐☐ UPI details ☐☐☐☐☐☐☐☐☐☐

Payment Option: ☐☐☐☐☐☐ Amount in words: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Whether premium payment in instalments option has been opted: Yes ☐ No ☐

If yes, please mention the frequency of premium payment: Monthly ☐ Quarterly ☐ Semi-annual ☐ Annual ☐

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 Proposal 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 Proposal 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.
For details of other nominees bank account, please attach a separate sheet.
Note : In case of multiple Nominee, bank account details will be taken for all.

AUTO - RENEWAL OPTION

Do You wish to avail an auto-renewal facility (ECS payment) by way of which we will automatically renew your Policy for the period for which it has been issued for. (Please tick Yes, if opted for) Yes ☐ No ☐

I/we hereby declare and undertake that the amount paid by me/us as premium for the aforementioned policy is out of my/our lawful and declared source of income

Signature of the proposer/customer: _____ Place: _____ Date: D D / M M / Y Y Y Y

MEDICAL AND LIFESTYLE INFORMATION

Important: You must answer the following questions truthfully. Not doing so affects your coverage in case of a Claim.
SECTION A: Have any of the person proposed to be insured ever suffered from / are suffering from any of the following:
Please tick 'YES" for insured wherever applicable and provide details in Section B

Sr.No.	Medical and Lifestyle Information	Insured 1	Insured 2	Insured 3	Insured 4	Insured 5
1.	**Hypertension (High Blood pressure) History :**	Y N	Y N	Y N	Y N	Y N
	a) Duration					
	b) Medications					
	c) Related Complications if any					
	d) Hospitalisation if any					
2.	**Diabetes Mellitus (Sugar) History :**	Y N	Y N	Y N	Y N	Y N
	a) Type I or Type 2					
	b) Duration					
	c) Medications - Insulin/ Tablets					
	d) Related Complications if any					
	e) Hospitalisation if any					
3.	**Hyperlipidemia (Cholesterol) History:**	Y N	Y N	Y N	Y N	Y N
	a) Duration					
	b) Medications					
4	Does any person proposed to be insured smoke or consume Tobacco in any form or alcohol. If yes, please indicate the quantity consumed. If not please indicate No.					
	a) **Smoking:** Cigarettes/Bidi/Cigar	Y N	Y N	Y N	Y N	Y N
	1. Number of Cigarettes/Bidi/Cigar per day					
	2. Number of years					
	b) **Tobacco in any form**	Y N	Y N	Y N	Y N	Y N
	1. Amount per day					
	2. Number of years					
	c) **Alcohol**	Y N	Y N	Y N	Y N	Y N
	1. Number of Units per week					
	2. Number of years					

		Yes / No	Insured No
5	**Heart and Circulatory Conditions/Disorders:** chest pain, angina, palpitations, congestive heart failure, coronary artery disease, heart attack, bypass surgery/angioplasty/ PTCA, valve disorder/replacement, pacemaker insertion, rheumatic fever, congenital heart condition, varicose veins, clots in veins or arteries, blood disorders, anti-coagulant therapy etc.	Y N	1 2 3 4 5
6	**Urinary Conditions/Disorders:** Blood in urine, increase in urinary frequency, painful/difficult urination Kidney and/or Bladder infections, stones of urinary system, kidney failure, dialysis or Any Other Kidney/Urinary Tract Or Prostate Disease	Y N	1 2 3 4 5
7	**Musculoskeletal Conditions/Disorders:** Joint/back pain Arthritis, Spondylosis,Spondylitis, SPinal disorders/Surgeries Osteoporosis, Osteomyelitis Joint Replacement Or Any Other Disorder of Muscle/ Bone/ Joint/ ligaments, tendons or discs, gout, herniated disc, fractures/ accidents/ implants, amputation/prosthesis, Muscle weakness, Polio etc	Y N	1 2 3 4 5
8	**Respiratory Conditions/Disorders:** Shortness/difficulty of breath, Tuberculosis, Asthma, Bronchitis, Chronic Obstructive Pulmonary Disease COPD,chronic cough , coughing of blood, etc or any Other Lung / Respiratory Disease	Y N	1 2 3 4 5
9	**Digestive Conditions/Disorders:** Jaundice, chronic diarrhea, intestinal bleeding/problems/polyps, diseases of the pancreas, liver or gall bladder, hepatitis A/B/C/other, jaundice, Ulcerative colitis, Chron's disease, Inflammatory/ irritable bowel disease, Cirrhosis, unexplained weight loss or gain, eating disorder or any Other Gastro Intestinal condition	Y N	1 2 3 4 5
10	**Cancer/Tumor:** Benign Or Malignant tumor, Any Growth/Cyst, any Cancer diagnosed earlier and/or treatment taken for cancer	Y N	1 2 3 4 5
11	**Brain/Nervous System/ Mental/Psychiatric Conditions/Developmental Disorders/Congenital/Birth defect:** Loss of consciousness, fainting, dizziness, numbness/tingling, weakness, paralysis, head injury, stroke, migraine headaches or chronic severe headaches, sleep apnea, multiple sclerosis, seizures/epilepsy or any Other Brain/ Nervous System Disease, Mental/Psychiatric disorder, ADHD, autism, disability or deformity whether physical or mental,etc.	Y N	1 2 3 4 5
12	**Female Reproductive Conditions/Disorders:** Pelvic pain, abnormal, menstrual bleeding abnormal PAP smear, endometriosis, Fibroid, Cyst/ Fibroadenoma, Bleeding Disorder, Pelvic infection Or Any Other Gynecological / Breast cysts/lumps/tumor	Y N	1 2 3 4 5
13	**Eye, Ear, Nose and Throat Disorders:** Cataract, glaucoma, Opticneuritis, retinal detachment, conjunctivitis, squint, ptosis, Blindness, refractive error/ spectacle number in dioptres; otitis media, Deviated Nasal Septum, Otosclerosis, Loss of speech, Hearing loss, nasal polyps, chronic sinusitis Any other disorder of Ear, Nose and Throat	Y N	1 2 3 4 5
14	**Sexually Transmitted Diseases:** HIV/AIDS, immunodeficiency or any venereal disease (VD)/ sexually transmitted disease(STD)	Y N	1 2 3 4 5
15	**Metabolic, Endocrine Conditions/Disorders and autoimmune/genetic disorder:** Adrenal/pituitary disorders, thyroid disorder, lupus, scleroderma, thyroid disorders, Thallasemia, anemia, Hemophillia, Obesity and related surgeries, etc.	Y N	1 2 3 4 5
16	Is any female member pregnant, tested positive with a home pregnancy test, or ectopic pregnancy, infertility treatment, planning for surrogacy or oocyte donation.	Y N	1 2 3 4 5
17	Does the person proposed to be insured suffer from any chronic or long-term medical condition, or have any other disability, abnormality or recurrent illness or injury or unable to perform normal activities?	Y N	1 2 3 4 5
18	Has any member consulted with or received treatment from any doctor or other health care provider for any other condition or symptom(s)/undergone any hospitalization/illness/surgery/ currently taking medication(s) for any condition or medical procedures (including diagnostic testing)	Y N	1 2 3 4 5
19	Does the individual have a family history of any disease (like Heart disease/ brain disease/ cancer/ organ failure/ autoimmune/ genetic disorder	Y N	1 2 3 4 5

SECTION B: Name and details of Illness / Medicine / Test / Surgery / Diopter grade (for questions answered as yes in SECTION A above)	Date of Last Consultation	Doctor's Name	Hospital Name & Phone No.
Insured 1:			
Insured 2:			
Insured 3:			
Insured 4:			
Insured 5:			

IMPORTANT NOTES

1. The information that you give to us on this proposal form or in any supplementary Information form 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.
2. 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.

IMPORTANT NOTES (CONTD.)

3. 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.
4. The list of exclusions/ inclusions and other policy details are indicative, for complete list and comprehensive details kindly refer policy wordings.
5. The Policy shall become voidable at the option of the Company, in the event of any established fraud or any material fact* information has been withheld by beneficiary or anyone acting on beneficiary's behalf to obtain insurance.

   **A material fact will mean and include all important, essential and relevant information, pertaining to the questions made in this proposal form, that are likely to influence company's acceptance or assessment of the proposal.*

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 policyaccept 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 liable for a penalty which may extend to Ten lakh rupees.

Terms and Conditions

- Bariatric Surgery Cover will have a waiting period of 2 years (30 days in case Jumpstart has been opted).
- In-patient Treatment applicable only in Plan A upto Rs 5 Lakh for Surrogate Mothers and Oocyte Donors will have a waiting period of 30 days.
- Initial waiting period of 30 days for all illnesses (except Hospitalization due to injury or Accident)
- If the Specific Illness Waiting Period Reduction Option has been opted, Specified illness/treatment will be covered after a waiting period of 12 months.
- If the PED Waiting Period Reduction Option has been opted, declared and accepted Pre-existing diseases will be covered after a waiting period of 12 months/24 months.
- Jumpstart cover will have a waiting period of 30 days.
- Under Optional Cover Health Check-up, pre-defined health check-up packages maybe modified from time to time without prior notice but the sum insured eligibility will not be changed.

DECLARATION (Applicable for Accidental Emergencies Cover for NRI)

I hereby declare that my permanent residence is and will be based outside geographical boundaries of India during the policy tenure.

Signature of the proposer/customer: _____ Place: _____ Date: D D / M M / Y Y Y Y

DECLARATION

I/We 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/We am/are authorized to propose on behalf of these other persons.

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 insurance company and that the policy will come into force only after full receipt of the premium chargeable.

I/We further declare that I/we will notify in writing any change occurring in the occupation or general health of the life to be insured/proposal after the proposal has been submitted but before communication of the risk acceptance by the company.

I/We declare and consent to the company seeking medical information from any doctor or from a hospital who at any time has attended on the life to be insured/proposed or from any past or present employer concerning anything which affects the physical or mental health of the life to be assured/proposer and seeking information from any insurance company to which an application for insurance on the life to be assured/proposer has been made for the purpose of underwriting the proposal and/or claim settlement.

I/We authorize the company to share information pertaining to my proposal including the medical records for the sole purpose of proposal underwriting and/or claims settlement and with any Government and /or Regulatory authority.

I/We authorize IL or any of its Agents and/service representatives/affiliates to contact me via SMS/Email/Phone/WhatsApp/ Social Media or any other modes on my registered phone number over-riding my 'DND' registration to make welcome calls/SMS, service calls/SMS, policy related information or any other commercial communication

I/We authorize IL or any of its service representatives/health service providers to contact me via SMS/Email/Phone/WhatsApp/ Social Media or any other modes and I/We have no objection to my/our medical information being saved for internal use.

I/We hereby give my/our consent to the Company to verify and obtain my/our identity/address proof through Central KYC Registry or UIDAI or through any other modes for the purpose of undertaking KYC.

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.

I/We understand that the Company has right to call for documents to establish source of funds

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.

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.

Signature of the proposer/customer: _____ Place: _____ Date: D D / M M / Y Y Y Y

Declaration when the proposal 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 proposal 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 proposal 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:

AGENT DECLARATION

I, _____ full name _____ in my capacity as an Insurance Advisor/ Specified Person (SP) of the Corporate Agent/Authorized employee of the Broker/Relationship Officer/Insurance Sales Persons (ISP) of Insurance marketing Firm, Rural Authorised 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.

Agent Name:_____

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

SP Name SP Code

License No. (Advisor/Corporate Agent/Broker/Relationship Officer/SP/ISP/RAP/VLE)