# ELEVATE PROPOSAL FORM

**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, established fraud or non-disclosure of any material fact 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 Income per annum

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

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

## 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) | Age | Date of Birth (DD/MM/YY) | Relationship with Proposer | Height (feet/inch) | Weight (kgs) | ABHA No. | Occupation | PAN No. |
|---|---|---|---|---|---|---|---|---|---|---|
| 1. | | | | D D/M M/Y Y Y Y | | | | | | |
| 2. | | | | D D/M M/Y Y Y Y | | | | | | |
| 3. | | | | D D/M M/Y Y Y Y | | | | | | |
| 4. | | | | D D/M M/Y Y Y Y | | | | | | |
| 5. | | | | D D/M M/Y Y Y Y | | | | | | |

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

Worldwide cover will not be available in case insured(s) are not Indian nationals and Indian residents.

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

Please generate your ABHA No. by visiting the official website ndhm.gov.in and share the same with us.

## 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* ☐ 4 Years* ☐ 5 Years* *In case the insured person in the policy is a surrogate mother, policy tenure of 3 years and above will be mandatory.

**Policy Type**

☐ Individual ☐ Floater

**Sum Insured**

☐ 5 Lakhs ☐ 7.5 Lakhs ☐ 10 Lakhs ☐ 15 Lakhs ☐ 20 Lakhs ☐ 25 Lakhs ☐ 50 Lakhs ☐ 1 Crore ☐ 3 Crore ☐ Unlimited sum insured

**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 | Infinite Care | ☐ YES | ☐ NO | 22 | Durable medical equipment | ☐ YES | ☐ NO |
| 2 | PowerBooster | ☐ YES | ☐ NO | 23 | Teleconsultations | ☐ YES | ☐ NO |
| 3 | JumpStart | ☐ YES | ☐ NO | 24 | Waiting period reduction option | ☐ YES | ☐ NO |
| 4 | Chronic Disease Management Program | ☐ YES | ☐ NO | 25 | Maternity waiting period reduction option | ☐ YES | ☐ NO |
| 5 | Maternity Benefit | ☐ YES | ☐ NO | 26 | Specific illness waiting period | ☐ YES | ☐ NO |
| 6 | New born baby cover | ☐ YES | ☐ NO | 27 | Worldwide cover waiting period | ☐ YES | ☐ NO |
| 7 | Vaccinations for new born in first year | ☐ YES | ☐ NO | 28 | Room modifier | ☐ YES | ☐ NO |
| 8 | BeFit | ☐ YES | ☐ NO | 29 | Network advantage | ☐ YES | ☐ NO |
| | a. Plan A | ☐ YES | ☐ NO | 30 | NRI Advantage Cover for NRI | ☐ YES | ☐ NO |
| | b. Plan B | ☐ YES | ☐ NO | 31 | Senior Care - Value Added Services | ☐ YES | ☐ NO |
| | c. Plan C | ☐ YES | ☐ NO | | a. Plan A | ☐ YES | ☐ NO |
| | d. Plan D | ☐ YES | ☐ NO | | b. Plan B | ☐ YES | ☐ NO |
| | e. Plan E | ☐ YES | ☐ NO | | c. Plan C | ☐ YES | ☐ NO |
| | f. Plan F | ☐ YES | ☐ NO | | d. Plan D | ☐ YES | ☐ NO |
| | g. Plan G | ☐ YES | ☐ NO | 32 | 2 - Hour Hospitalization | ☐ YES | ☐ NO |
| 9 | Worldwide cover | ☐ YES | ☐ NO | 33 | Vital Essence# # | ☐ YES | ☐ NO |
| 10 | Claim Protector | ☐ YES | ☐ NO | 34. | Elevate HER-Women Care followed by Plan name | | |
| 11 | Inflation Protector | ☐ YES | ☐ NO | | **Standard Plan** | | |
| 12 | Domestic Air Ambulance | ☐ YES | ☐ NO | | a. Elevate HER Bloom | ☐ YES | ☐ NO |
| 13 | Convalescence benefit | ☐ YES | ☐ NO | | b. Elevate HER Thrive | ☐ YES | ☐ NO |
| 14 | Nursing at home | ☐ YES | ☐ NO | | c. Elevate HER Nurture | ☐ YES | ☐ NO |
| 15 | Compassionate | ☐ YES | ☐ NO | | d. Elevate HER Harmony | ☐ YES | ☐ NO |
| 16 | Health Check-up | ☐ YES | ☐ NO | | **Plus Plan** | | |
| 17 | Critical Illness | ☐ YES | ☐ NO | | e. Elevate HER Bloom Plus | ☐ YES | ☐ NO |
| 18 | Personal accident | ☐ YES | ☐ NO | | f. Elevate HER Thrive Plus | ☐ YES | ☐ NO |
| 19 | Voluntary co-payment# | ☐ YES | ☐ NO | | g. Elevate HER Nurture Plus | ☐ YES | ☐ NO |
| 20 | Voluntary deductible# | ☐ YES | ☐ NO | | h. Elevate HER Harmony Plus | ☐ YES | ☐ NO |
| 21 | Dependent accommodation benefit | ☐ YES | ☐ NO | 35. | Power Booster Plus | ☐ YES | ☐ NO |

**Important Points**

a. Power Booster Optional Cover will not be available for policies with Unlimited Annual Sum Insured.
b. Jumpstart Optional Cover will have to be opted for a period of 3 continuous policy years.
c. 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 optional cover 16 - Health check up if opted. CDMP & Health Check - Up is available to insured member(s) of age 18 years and above.
d. Maternity Benefit Optional cover and Elevate HER Women care cover will not be available outside the geographical boundaries of India.
e. New Born Baby cover and vaccinations for new born in first year will be available only if Maternity benefit or Elevate HER Nurture plan/Elevate HER Nurture Plus plan under Elevate HER Women care is opted.
f. Worldwide cover is not available in optional covers Maternity Cover, Elevate HER Women care, Infinite care, Reset Benefit, Claim Protector, NRI Advantage cover for NRI, waiting period reduction option and specific illness waiting period reduction option.
g. Waiting Period Reduction Option will have to be opted for a period of 3 continuous policy years.
h. Maternity Benefit Waiting Period Reduction Option, Specific Illness Waiting Period Reduction, Worldwide Cover Waiting Period Reduction Option will have to be opted for a period of 2 continuous policy years.
Claims under NRI Advantage cover for NRI will be paid for base covers only within geographical boundaries of India. All waiting periods as per the policy terms and conditions will be applicable.
I. Critical illness available only for person age between 18 to 50 years at the time of first policy issuance.
j. Senior Care - Value Added Services available only for 55 years & above.
#If Voluntary Co - payment is opted Voluntary deductible will not be available and visa versa.
##If you opted Vital Essence optional add-on, you shall not be eligible to opt for the Voluntary Co-payment optional add-on & Voluntary Deductible optional add-on. Also, 20% of Co-pay will be applicable on each and every claim in the policy i.e. Base as well as optional add on.
K. The premium applicable will reflect the inclusion of the Vital Essence add-on, along with adjustments made based on your health profile at the time of policy issuance. In case, if the Vital Essence add-on is not continued at the time of renewal, the associated discount shall be withdrawn and the renewal premium shall be recalculated, basis the risk assessment. This clause applies only if the Vital Essence add-on was selected during the initial policy term and is discontinued at renewal.
L. For Elevate HER women care following plans are available:
i) Elevate HER Bloom- Available for 14-22 years
ii) Elevate HER Thrive- Available for 23-45 years
iii) Elevate HER Nurture- Available for 23-45 years
iv) Elevate HER Harmony- Available for 46-60 years
v) Elevate HER Bloom Plus-Available for 14-22 years
vi) Elevate HER Thrive Plus- Available for 23-45 years
vii) Elevate HER Nurture Plus- Available for 23-45 years
viii) Elevate HER Harmony Plus- Available for 46-60 years
Elevate HER Nurture/Elevate HER Nurture Plus can be opted with base SI of >=7.5 lakh.
M. Power Booster Plus optional cover can only be opted at the time of renewal. It will not be available for policies with Unlimited Annual Sum Insured. Only one of the two add ons- Power Booster & Power Booster Plus shall be available in a Policy.

| | |
|---|---|
| **Voluntary co-payment** (If Opted) | ☐ 10% ☐ 20% ☐ 30% ☐ 40% ☐ 50% |
| **voluntary deductible** (If Opted) | ☐ Rs. 10,000 ☐ Rs. 20,000 ☐ Rs. 30,000 ☐ Rs. 40,000 ☐ Rs. 50,000 |
| **waiting period with options** (If Opted) | 1. Waiting period reduction option ☐ 12 Months ☐ 24 Months<br>2. Specific illness waiting period reduction option ☐ 12 Months<br>3. Worldwide cover waiting period reduction option ☐ 12 Months<br>4. Maternity waiting period reduction option ☐ 12 Months |
| **Room Modifier** (If Opted) | ☐ Any room rent category<br>☐ Twin sharing room only<br>☐ 1% of Annual Sum Insured for normal room and 2% of Annual Sum Insured for ICU per day*<br>*Available for Annual Sum Insured Rs. 5 Lakhs and Rs. 7.5 Lakhs only. |

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.

**Do you wish to avail a physical copy of your policy documents? Yes ☐ No ☐**

## 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

## BANK ACCOUNT DETAILS OF NOMINEE

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

## 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 N | 1 2 3 4 5 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 | | | Y N | 1 2 3 4 5 | |
| | 2. Number of years | | | | | |
| | c) **Alcohol** | Y N | Y N | Y N | Y N | Y N |
| | 1. Number of Units per week | | | Y N | 1 2 3 4 5 | |
| | 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 |

| | | Yes / No | Insured No |
|---|---|---|---|
| 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 |
| 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, infertility treatment, ART (Artificial reproductive treatment) 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 |
| **Following Questions are to be answered if Personal Accident benefit is opted for:** | | | |
| 20. | Have you ever been entrusted with prominent public functions, for example, Heads of State or of Government, senior politicians, senior government, judicial or military officials, senior executives of state owned corporations or important political party officials? | Y N | 1 2 3 4 5 |
| 21. | Does your job require you to be involved with any hazardous activity, significant manual labor, operating heavy machinery, handling hazardous material, working at heights/underground /construction sites, oil rigging, high voltage, high temperature, working in aircrafts or sea-going vessels or adventure /extreme sports or armed forces? Please specify if any other profession | Y N | 1 2 3 4 5 |
| 22. | Have you ever been diagnosed with or consulted a doctor or advised surgery for any of the following? Paralysis, Epilepsy/Fits/Seizures, Physical disability/defects/ deformity, Psychiatric disorder, defect in sight/hearing/ speech. or any terminal illness or any illness or disease causing restriction to activities. If yes, then please furnish disease name, date of diagnosis, disability %, Last consultation date, name of the surgery, details of treatment taken. | Y N | 1 2 3 4 5 |

*Note: The above list of questions is subject to modification as per the requirement.*

| 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.
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 untrue or incorrect statement, misrepresentation, established fraud or non-disclosure of material particulars in the Proposal Form/personal statement, declaration and connected documents, 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 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.]

**Terms and Conditions**

- Loyalty Bonus and Infinite Care not available for Unlimited Sum Insured.
- Infinite Care is available only for any one claim in entire life of the Policy and not applicable in case the Insured Person has opted for in-patient treatment for Surrogate Mothers and Oocyte donors and for Worldwide Cover.
- Bariatric Surgery Cover will have a waiting period of 2 years (30 days in case Jumpstart has been opted).
- In-patient Treatment 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 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.
- As Per Optional Cover Opted Maternity benefit will have a waiting period of 12 Months/24 Months. Applicable only if Self and Spouse both are covered under a floater policy and age of female spouse is between Age 18 to 50 Years.
- As Per Optional Cover Opted Worldwide cover will have a waiting period of 12 Months/24 Months. Applicable only up to 65 years of age and sum insured for policies with unlimited sum insured will be restricted to Rs. 3 Crore.
- Jumpstart cover will have a waiting period of 30 days. This waiting period will not be applicable for Worldwide Cover.
- Reset benefit will trigger unlimited times for any illness/disease/injury. Not available for unlimited sum insured and for the first claim made in the Policy Year.
- 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.
- Infinite Care has to opted within a time period of 2 Policy Years (irrespective of Policy Tenure). The optional cover will not be available at the time of second renewal in case of single year policies and can be opted only at the time of policy inception for multi-year policies.

  Maternity benefit and Elevate her cannot be opted together.
- New Born Baby Cover and Vaccinations for Newborn Baby in the first year can be opted only with Maternity Benefit or Elevate HER Nurture plan/Elevate HER Nurture Plus under the Elevate HER.
- The benefits available in the Optional Cover "Elevate HER" shall be over and above the benefits available in other optional covers
- 30-day Waiting Period will be applicable for Elevate Her Bloom, Elevate Her Thrive, Elevate Her Harmony Diagnostic wallet and Elevate HER GynaeCare Visit-OPD consultation.
- Power Booster (Super Loyalty Bonus) and Power Booster Plus cannot be opted together.

## 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/ 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)