Enrolment form No._____

PROPOSAL FORM - FAMILY SHIELD

FOR OFFICIAL USE ONLY

URN No.: PF/4172/01 Business 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:

Permanent Address :

Landmark:

City/Town: State: Pin Code:

Mailing Address :

Landmark:

City/Town: State: Pin Code:

Mobile Number*: E-mail ID:

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

GSTIN No.: Pan No.:

LAN No.: Age (in years)

Are you an existing customer of ICICI Lombard, ☐ Yes ☐ No

If Yes, then kindly provide the policy number:

Occupation: Salaried ☐ Self Employed ☐ Professional ☐ Others ☐ Details _____

Occupation and Nature of Business/Work: Income per annum

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

* Aadhar details to be added if mandated by the Regulator in future

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.

INSURED DETAILS - PART B

Sr. No.	Reference	Insured Name	Mobile Number	E-Mail ID	PAN	Relationship with Proposer	Gross Annual Income
1	Insured 1						
2	Insured 2						
3	Insured 3						
4	Insured 4						

Occupation: Salaried ☐ Self Employed ☐ Professional ☐ Others ☐ Details _____

RISK DETAILS

Reference	DOB	Age (in years)	Gender	Occupation	Nominee Name	ABHA No.	Relation of Nominee with the Insured	Name of Appointee (in case Nominee is a minor)	Date from which insured person continuously obtaining Health Insurance in India	Pre Existing Disease, if any
Insured 1										
Insured 2										
Insured 3										
Insured 4										

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.

Is any of the above insured person holding a Personal Accident Policy or a similar Health Cover from ICICI Lombard or Any Other Insurance Company? ☐ No ☐ Yes (Details to be provided in the below format)

Reference	Existing policy number	Existing Sum Insured	Claim Details, if any
Insured 1			
Insured 2			
Insured 3			
Insured 4			

Any Additional Information relevant to the policy being applied for:

_____

_____

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: ☐☐☐☐☐☐☐☐

TABLE OF BENEFITS - PART C

Kindly mention the Sum Insured against the covers for which insurance is required. Customer can opt for one or more of the sections by opting for at least one base cover defined under each section. Extension covers cannot be chosen independently and has to be opted along with any one base cover of the respective section.

Annuity Benefit is available for all Death and Permanent Total Disability related covers. If any cover is required on periodic claim payment basis then kindly specify the same under Sum Insured column of respective benefits.

Section	Cover Name	Sum Insured			
		Insured 1	Insured 2	Insured 3	Insured 4
SECTION A	Specific vector borne disease related Hospitalization Benefit				
	Rabies and Tetanus related Hospitalization Benefit				
	Rabies and Tetanus related Death Benefit				
	Specific Gastrointestinal Infections related Hospitalization Benefit				
	Specific Viral Infections related Hospitalization Benefit				
	Specific Nervous System infections Benefit				
SECTION B (Base Cover)	Hospital Daily Cash Benefit				
SECTION B (Extension Cover)	Intensive Care Unit (ICU) Cash Benefit				
SECTION C (Base Cover)	Accidental Death Benefit				
	Permanent Total Disablement (PTD) Benefit				
	Permanent Partial Disablement (PPD) Benefit				
	Temporary Total Disablement (TTD) Benefit				
	Adventure Sports Benefit				
	Children's Education Grant Benefit				
	Orphan Benefit				
	Parental care Benefit				
	Accidental Hospitalization Expenses Benefit				
	Accidental Hospitalization Daily Cash Benefit				
	Common Carrier Accident Benefit				
	Loan Protection Benefit				
	Assault Benefit				
	Mysterious Disappearance Benefit				
	Reconstructive Surgery Benefit				
	Catastrophic Evacuation Benefit				
	Physical Rehabilitation Benefit				
	Loss Of Job				
	Recovery Benefit				
	Diagnostic Test Benefit				
SECTION C (Extension Benefits)	Lifestyle Support Benefit				
	Last Rite Benefit				
	Counseling Benefit				
	Repatriation in case of Permanent Disability Benefit				
	Accidental Pre & Post Hospitalization Expenses Benefit				
	Air Ambulance Benefit				
	Comatose Benefit				
	Broken Bones Benefit				
	Compassionate Visit Benefit				

SECTION C (Extension Benefits)	Burns Benefit				
	Ambulance Charges Benefit				
	Chauffeur Cash Benefit				
	Skill Development Benefit				
	On Duty Enhanced Benefit				
	Home Tuition Benefit				
	Outstanding Bills Payment Benefit				
	Surgery Benefit				

RISK DETAILS - PART D

Policy Start Date: D D M M Y Y Y Y Policy Tenure _____

PREMIUM DETAILS

Total Premium (Incl. GST) _____ Mode of Payment _____

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

HEALTH & INCOME DECLARATION - PART E

I, hereby declare that none of the insured person listed in Part C of this form and intended to be covered under this policy suffer from Paralysis, Stroke (including any residual symptoms of an old stroke), Seizures / Epilepsy / Vector Borne Disease and that none of them have any Physical Disability / Deformity / Amputation of Limb. I, also declare that the Sum Insured opted is not greater than _____ times of the annual income of the respective insured person (This shall be subject to prevalent UW guidelines & shall be modified accordingly).

Name: _____

Date D D M M Y Y Y Y Place _____

Designation: _____ Proposer's Signature _____

DETAILS OF OTHER HEALTH INSURANCE POLICIES IN EXISTENCE

Is any proposer or the person proposed, already insured under a plan with ICICI Lombard GIC Ltd? ☐ Yes ☐ No

If yes please indicate below the Policy number(s) (Please mention proposal number in case of pending proposal.)

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

DETAILS OF ALL PREVIOUS HEALTH INSURANCE POLICIES SINCE INCEPTION

Name of Insurer ☐☐

Policy Period ☐☐☐☐☐☐☐☐☐☐ Name of the product ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Do you wish to avail policy documents in physical form: Yes ☐ No ☐

GENERAL DECLARATION

1. 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.
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 insurance company and that the policy will come into force only after full receipt of the premium chargeable.
3. 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 or during the policy period.
4. 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.
5. 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.
6. 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.
7. 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.
8. 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.
9. 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.
10. I/We understand that the Company has right to call for documents to establish source of funds.

Date ☐D☐D☐M☐M☐Y☐Y☐Y☐Y Place ☐☐☐☐☐☐☐☐☐☐☐☐ Applicant Signature _____

DECLARATION IN CASE OF PREMIUM PAYMENT ON INSTALLMENT BASIS

I hereby declare that I have opted for payment of premium towards this policy on instalment basis and I hereby consent for the following:

i. Installment premium shall be collected on <Monthly/Quarterly/Half-yearly/Yearly> basis from DD/MM/YYYY to DD/MM/YYYY

ii. In case of installment premium being paid through ECS mode, I shall provide a consent for the same on an ECS mandate form and shall attach the same with this application

iii. I have been informed that the total premium shall be INR _____ and accordingly, the premium towards each installment shall be INR _____

iv. I have been informed that upon non-payment of any premium instalments for up to 7 days from the due date of such installment thereof, this Policy shall cease to operate from the time and date of the default in payment of such premium instalment

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: _____

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.]

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: _____