Enrollment form No._____
URN No PF/4202/00

ICICI LOMBARD GROUP CRITI SHIELD PLUS PROPOSAL FORM

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

Insurance is a contract of Utmost Good Faith requiring the Proposer not only to disclose all material facts, but also not to suppress any material facts.

*A material fact will mean and include all important, essential and relevant information pertaining to the questions raised below herein, that is likely to influence the Company's acceptance or assessment of the proposal.

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 this 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 enrollment form.

Note: The liability of the company does not commence until this proposal has been accepted and premium is duly received by the company.

I/ We hereby agree and confirm that if the amount realised by the insurer is less than the premium payable for sum insured proposed for insurance or scope of cover desired by me, the application shall be considered for acceptance for a reduced sum insured appropriate to the premium realised by the insurer and the policy shall finalised and issued accordingly.

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

CUSTOMER INFORMATION - PART A

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

Proposer's Name (please leave a space after each part of name) Annual Income from all sources: _____

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 ☐

Occupation: ☐ Salaried ☐ Self Employed ☐ Professional ☐ Retired ☐ Housewife ☐ Student ☐ Others Details_____

Nationality: ☐ Indian ☐ Others (please specify) _____ Residential Status: ☐ Indian Resident ☐ Non Resident Indian

Annual Income: ☐ Less than 5 Lacs ☐ Between 5 - 10 Lacs ☐ Between 10 - 20 Lacs ☐ 20 Lacs and above

☐ above > 30 Lacs _____

ABHA No _____

I agree to share my medical records with ICICI Lombard / TPA through ABHA:
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;

GST Number: (It Applicable) _____ PAN Card No.: _____

Correspondence Address : _____

_____ Landmark: _____

City: _____ State: _____ Pin Code: _____

Mobile Number*: _____ E-mail ID: _____

Permanent Residence Address: _____

_____ Landmark: _____

City: _____ State: _____ Pin Code: _____

CKYC

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

Please provide us the details of other policies to enable us to co-ordinate with other insurer at the time of claim to settle the balance claim amount in case sum insured in this policy is exhausted.

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					
Name of Bank					
Account Number					
MICR					
IFSC					
Mailing Address					
Permanent Address					
Mobile Number					
Email ID					
In case of minor Nominee, kindly provide details of authorised Appointee					
Name of Appointee					
Name of Bank					
Account Number					
MICR					
IFSC					
Mailing Address					
Permanent Address					
Mobile Number					
Email ID					

PROSPECT DETAILS

SECTION I : (If Insured and prospect are same then skip SECTION I and move to SECTION II)

Name of the Prospect: Mr./ Mrs./ Ms./ Dr.

Gender: Male Female Third gender Mobile Number*:

Email ID

ABHA No.

I agree to share my medical records with ICICI Lombard / TPA through ABHA:

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

SECTION II :

Date of Birth: D D M M Y Y Y Y Occupation: Salaried ☐ Self-employed ☐

Status (please tick any one): Private Limited Co. ☐ Public Ltd. Co. ☐ Unincorporated Association or Body of Individuals ☐

Partnership/LLP ☐ Trust/ Foundation ☐ NGO/NPO ☐ Government ☐ Others ☐ _____

Relationship of Insured with Prospect: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Nominee Name: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Relationship of Nominee with Prospect: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Loan Status of the Prospect: Main Applicant ☐ Co-applicant ☐ Guarantor ☐

PAN No.: ☐☐☐☐☐☐☐☐☐☐ Aadhaar No.: ☐☐☐☐☐☐☐☐☐☐☐☐

LOAN DETAILS

Loan Account No. (LAN): ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ One EMI Amount: ☐☐☐☐☐☐

Type of Loan to be insured: ☐ Home Loan ☐ LAP ☐ Others _____

Loan Sanction Date: D D M M Y Y Y Y Loan Sanction Amount: ☐☐☐☐☐☐☐☐☐☐☐☐☐

Loan Disbursal Date: D D M M Y Y Y Y Loan Disbursal Amount: ☐☐☐☐☐☐☐☐☐☐

PREMIUM DETAILS (INCLUSIVE OF GST)

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

DD/ Cheque No.: ☐☐☐☐☐☐☐☐ Funded ☐ Non Funded ☐ Bank Name: ☐☐☐☐☐☐☐☐☐☐

DD/ Cheque Date: D D M M Y Y Y Y NEFT Transaction ID: ☐☐☐☐☐☐☐☐☐☐☐☐

*Registered GST: Yes ☐ No ☐ (One Policy One Invoice)

If Yes, then please provide GSTIN: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Address (Registered under GST): ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

GROUP CRITI SHIELD PLUS - PART B

Policy Term: ☐☐☐ Years **Type:** ☐ New ☐ Renewal

In case of renewal please mention policy number ☐☐☐☐☐☐☐☐☐☐☐☐

DETAILS OF THE INSURANCE PRODUCT/ PLANS

Please fill the form as per your requirement.

Tenure ☐ 1 Year ☐ 2 Years ☐ 3 Years ☐ 4 Years ☐ 5 Years **Plan Type** ☐ Individual ☐ Multilife

Plan Options ☐ Individual ☐ 1 A + 1 C ☐ 1A + 2C ☐ 2A ☐ 2A+1C ☐ 2A + 2C ☐ 2A + 3C

Plan Details: Benefit 1 - Comprehensive Critical Illness ☐ Benefit 1.1 ☐ Benefit 1.2 ☐ Benefit 1.3

☐ Cancer and Blood Disorders ☐ Heart and Blood Vessel ☐ Major Organs ☐ Nervous System ☐ Other Illness

Plan Details: Benefit 2 - Extensive Critical Illness ☐ Major+Minor ☐ Major

Sum Insured Insured 1 _____ Insured 2 _____ Insured 3 _____ Insured 4 _____ Insured 5 _____

Add-ons Cover ☐ ICU Benefit ☐ Cancer Restore ☐ Major Surgical Procedure ☐ Personal Accident

Loss of Pay _____ Payout Amount _____ /Weeks _____ Payout Period (Max) _____

Loss of Income on account of loss of Employment • Payout Amount _____

Waiting Period: ☐ 30 days ☐ 60 days ☐ 90 days ☐ 120 days ☐ 150 days

Survival Period: ☐ 0 days ☐ 3 days ☐ 7 days ☐ 14 days **ICU Benefit: Survival Period:** ☐ 5 days ☐ 7 days

Plans & Sum Insured & other details opted above will apply for all family members.

*Cancer restore only applicable where Cancer Cohort has been opted.

PAYMENT DETAILS

Premium Amount ₹: _____ Cheque/DD Number _____

Payment Option: Cheque ☐ DD ☐ NEFT ☐ RTGS ☐ Dated: D D M M Y Y Y Y

Amount in words _____

BANK ACCOUNT DETAILS

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

Bank _____ Branch _____

MICR _____ IFSC* _____

Account Number: _____ Name of Account Holder _____

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 (Please fill ECS annexure if ticked yes)

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

Date D D M M Y Y Y Y

Signature of the proposer/customer _____

Place _____

MEDICAL AND LIFESTYLE INFORMATION

Important: You must answer the following questions truthfully. Not doing so affects your coverage in case of a Claim.

Have any of the person proposed to be insured ever suffered from/ are suffering from any of the following:

	Medical and Lifestyle Information	Insured 1	Insured 2	Insured 3	Insured 4	Insured 5
1	Please confirm if you are suffering from Diabetes , Hypertension , Hyperlipidemia (High Cholesterol) History If yes, Please specify the duration of illness_____					
2	Has Prospect consulted with any doctor or other health care provider for any other condition or symptom(s)/undergone any hospitalization for any illness or surgery. If yes, Please specify details along with the duration_____					
3	Is Prospect currently taking medication(s)/ or taken in the past for any condition or medical procedures (including diagnostic testing). If yes, Please specify details along with the duration_____					
4	Any other medical condition/disability/Physical deformity arising out of any illness or Prior History of Accident: Yes No If yes, Please specify details_____					
5	Does the prospect have any other Secure Mind/ Group Secure Mind/ Critical Illness/ Health/ Income Protect/ ICICI Lombard Criti Shield Plus/ Womens Cancer Shield/ Universal Protection Insurance Policy with ICICI Lombard GIC Ltd. or similar policies with any other insurance company? If yes, please provide the policy number and sum insured_____					
6	Has any of your previous health proposal been declined by ICICI Lombard GIC Ltd. /any other insurance company in the past. If yes, Please specify details:_____					
7	Have you smoked or used any substance or product containing tobacco, or alcohol or any other substance? If yes, please state duration and average daily consumption and type _____					

8	Have you suffered from any Heart and circulatory conditions/ Blood disorder conditions/ Respiratory conditions/ Cancer/ Neurological conditions/ Sexually transmitted Diseases Conditions related to: Nervous system/ Kidney/ Liver/ Urinary tract/ Digestive disorders/ Musculoskeletal/ eyes, ears, nose, throat/ auto immune/ endocrine system If yes, please specify _____					

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

PAST CLAIM EXPERIENCE

Please mention if you have lodged any claim in the past under Secure Mind / Group Secure Mind / Income Protect / CI / Health policy with ICICI Lombard GIC Ltd. / ICICI Lombard Criti Shield Plus/ Womens Cancer Shield / Universal Protection Insurance Policy Under similar policies with other insurance companies in the past. If yes, please specify details:

_____

_____

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

DECLARATION APPLICABLE FOR ALL SECTIONS

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 enrollment form 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 have been provided with the detail terms of the policy. I have read, understood and aware of the details terms of the policy.
6. I have read and understood the terms and conditions of the Policy and confirm to abide by the same. I hereby agree that the insurance coverage/ risks under the policy will commence subject to realization of full premium. Receipt of this form by the Company shall not be construed as acceptance of proposal. Company in its sole discretion reserves the right to accept or reject any proposal withoutassigning any reasons thereof.
7. 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.
8. I declare that the contents of this products covered in this form and the form have been fully explained to me and I have fully understood the significance of the proposed contract
9. I understand that the insurance coverage will commence not earlier than the date of disbursal of loan as referred overleaf or after the full premium is received by ICICI Lombard General Insurance Co. Ltd whichever is later subject to underwriting approval by ICICI Lombard General Insurance Company Ltd.
10. I also confirm and declare that the persons whose details have been mentioned in this enrollment form for coverage are the Applicant(s)/ Co-applicant(s) / Guarantor of the loan.
11. I hereby confirm that I am aware that Enrollment to this product is purely voluntary and is not linked to me availing of any other facility from the bank.
12. I hereby confirm that I have insurable interest in the policy and the premium is not borne by any third party entity or person.
13. I/We hereby give my/our consent to enroll me/us into Group Secure Mind policy underwritten by ICICI Lombard General Insurance Co. Ltd. (IRDA Reg No 115).
14. I/We agree to abide by the Terms & Conditions of the policy and provide my consent to share my personal details, as required, regarding my enrollment into the policy with the Insurer.
15. 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.
16. 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.
17. I/We understand that the Company has right to call for documents to establish source of funds
18. 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.

19. 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.

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

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: _____

_____

_____

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

DETAILS OF ALL PREVIOUS HEALTH INSURANCE POLICIES SINCE INCEPTION

Name of Insurer _____

Policy Period _____ Name of the product _____

DECLARATION FOR ASSIGNMENT

I Mr./Mrs./Ms: _____- here by assign the claim amount payable in the event of my Death / Diagnosis / Undergoing Surgical Procedures as covered under the policy issued by ICICI Lombard General Insurance Company Limited against the above mentioned product(s), to _____(Channel name) and I further declare that this receipt shall be sufficient discharge to the Company.

Terms & Conditions

- From the policy start date, the amount payable by Company to the insured and all rights, title, benefits and interest of the insured under this policy stand assigned in favor of the "Bank / financial institution as named in the Schedule I of this policy"
- Upon any amount becoming payable under this policy, the same shall be paid by the Company to the "Bank/Financial Institution as named in Schedule I of this policy", but not exceeding the Principal outstanding as defined under the policy. In the event of any amount payable under this policy exceeding the Principal outstanding, the Company shall pay such amount as exceeding the Principal outstanding, to the insured.
- The receipt of such amount in the manner aforesaid by the Bank/Financial Institution as named in the Schedule I of this policy, shall completely discharge the Company from all the liability under the policy and this shall be binding on the insured and the heirs, executors, administrators, successors or legal representatives of the insured, as the case may be.

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

Witness Name: _____

Address: _____

_____

INTERMEDIARY DECLARATION AND DETAILS/PRINCIPAL OFFICER DETAILS

I, _____<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:

Name: _____

Code: _____ Contact No.: _____

Email ID of the branch: _____

Branch/Office: _____

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.]