ICICI Lombard
Nibhaye Vaade

Proposal Form No. (For Official Use Only): _____

URN No.- PF/4050/00

Globetrotter - Overseas Individual Student Travel Insurance - Proposal Form

GUIDELINES FOR COMPLETION OF THE FORM

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 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. If you think any fact is material, please disclose it.
3. 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 been withheld by the Proposer or any one acting on his behalf.
4. Kindly contact the Company's Offices or Agents for any doubts or clarifications on the proposal form.

NOTE: The liability of the Company does not commence until this Proposal has been accepted by the Company and premium received.

PROPOSER/ CUSTOMER INFORMATION

Proposer's Name (First) (Middle) (Last)

Mr./ Ms./ Dr.:

Date of Birth: D D M M Y Y Y Y Sex: Male ☐ Female ☐ Third Gender ☐ Marital Status ☐ Married ☐ Unmarried ☐

OCCUPATION DETAILS: ☐ (a) Salaried ☐ (b) Self Employed/ Business ☐ (c) Other (Please specify)_____

Correspondence Address:

City: State: Pin code:

ABHA no. Telephone Number (with TD Code): Fax (with STD Code):

Income per Annum CKYC no.

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

Mobile Number: Email:

Mother's Maiden Name: (First) (Middle) (Last)

Are you or any of the proposed applicants/beneficial owner a PEP* or a Family member/ Close relatives/Associates of PEPs? Yes ☐ No. ☐

If yes, explain nature of relationship and position held by PEP: _____

*Politically Exposed Persons (PEPs) are individuals who are or have been entrusted with prominent public functions in a foreign country, e.g., Heads of States/Governments, senior politicians, senior government/judicial/military officers, senior executives of state-owned corporations, important political party officials, etc.

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

RISK INFORMATION

Period of Insurance From: D D / M M / Y Y Y Y Period of Insurance to: D D / M M / Y Y Y Y

***Policy Start date should be on or before Trip Start date**

Geographical Scope	Is the customer currently in India	Purpose of Visit	Plan	Medical Sum Insured	Premium inclusive of Service Tax (INR)
Worldwide ☐	Yes ☐	Business ☐ Holiday ☐	Gold ☐	USD 500,000 ☐	
		Holiday ☐ Study ☐	Bronze ☐	USD 250,000 ☐	
Excluding USA/ Canada ☐	No ☐	Aviation ☐ Adventurous ☐	Gold Plus ☐	USD 100,000 ☐	
		Activity ☐		USD 50,000 ☐	

Type of Individual	Type of Entity	Additional Information	Resident of India
Salaried ☐	Partnership Firm ☐ Company ☐	Annual Income (INR)	Yes ☐
Self-Employed ☐	Others ☐	Do you own a Bank Account: Yes ☐ No ☐	No ☐
Professional ☐	If others, please specify _____	Do you file Income Tax Return: Yes ☐ No ☐	

DETAILS OF PERSONS TO BE COVERED

Name as per Passport	Date of Birth	Passport No.	Pre-existing ailments history	Past Hospitalisation/ Medical treatment details	Any Current Illness/ injury	Nominee Name	ABHA No.	Relationship to Insured

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.

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.				
Eamil ID				
Present Address				
Permanent Address				

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

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

	Pre-Existing Disease - Please declare if any of the insured tra veling is suffering from/has ever suffered from or had symptoms f or, taken medications/has undergone any hospitalisation/ surgery for the below mentioned diseases	**Yes**	**No**
a.	**Heart Disease** - Heart and Circulatory Conditions/ Disorders: Chest pain, angina, heart failure, coronary artery disease/blockage, heart attack, cardiac bypass surgery/ angioplasty, valve disorder/ replacement surgery, pacemaker insertion, congenital (by birth) heart condition, abnormal heart rhythm or any type of heart disease		
b.	**Liver Disease:** Chronic liver failure or disease, liver cirrhosis, liver transplant, autoimmune liver disease, biliary cirrhosis, fulminant/ recurrent hepatitis, shrunken liver, fibrotic liver and acute & chronic pancreatitis		
c.	**Kidney Disease:** Chronic kidney failure or disease, kidney transplant, dialysis, nephropathy, kidney cyst, polycystic kidney disease, nephritic syndrome, solitary kidney, renal mass, hydronephrosis, shrunken kidney and nephritic syndrome		
d.	**Cancer:** Any type of Cancer or tumor of any kind.		

FAMILY DOCTOR'S DETAILS

Doctor's Name: (First) (Middle) (Last)

Mobile:

ADDITIONAL INFORMATION TO BE COMPLETED BY THE STUDENT

University Details					
Name of University	**Course Name**	**University Address**	**City**	**State**	**Country**

SPONSOR'S DETAILS

Sponsor's Name	Relationship to Insured	Sponsor's Address	Date of Birth	Contact Number
			D D / M M / Y Y Y Y	

PAST INSURANCE DETAILS

Sr. No.	Policy Period	Insurance Company	Product name	Date of issuance of First Policy	Premiums Paid	Claims
1.						
2.						
3.						

Dated D D M M Y Y Y Y Place:

Proposer's/ Insured's Signature

BANK ACCOUNT DETAILS

	Bank Details of insured	Bank Details of Nominee	Bank Details of Appointee
Beneficiary Name			
Bank Name			
Bank Account Number			
IFSC CODE			
MICR NUMBER			
BRANCH			

PAYMENT DETAILS

Cash Cheque DD Credit/ Debit Card Premium Amount `

Cheque/ DD No. Cheque/ DD Date D D / M M / Y Y Y Y Branch (if cheque)_____

Account holder name :

Bank name : Account No. :

IFSC Code :

ANY ADDITIONAL INFORMATION RELEVANT TO THE POLICY APPLIED FOR

Note: Please use additional sheets if space is not sufficient to complete the details.

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 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.
- I agree that the Policy shall become voidable at the option of the company, in the event of misrepresentation, or established fraud or non-disclosure by the Insured or anyone acting on his behalf to obtain any benefit under this Policy.
- I have read and understood the policy terms & conditions and agree to abide by them.
- I/ we hereby agree that the insurance coverage under the policy will commence only on realization of full premium. Receipt of proposal form by the company shall not be construed as acceptance of proposal.
- 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.

Proposer's Name:

Date: D D / M M / Y Y Y Y Place: Proposer's 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

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:

INTERMEDIARY DECLARATION AND DETAIL/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) Ware 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:

STATUTORY WARNING

PROHIBITION OF REBATES (Under Sec 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.

ICICI Lombard
Nibhaye Vaade

ICICI Lombard General Insurance Company Limited

Mailing Address: Interface Building No.11, 401/402, 4th Floor, New Link Road Malad (W), Mumbai - 400 064.

Registered Office Address: ICICI Lombard House, 414, Veer Savarkar Marg, Near Siddhi Vinayak Temple, Prabhadevi, Mumbai 400 025.

Visit us at www.icicilombard.com • Mail us at customersupport@icicilombard.com Toll Free No.: **1800 2666** • Chargable No.: **+91 92236 22666**

Insurance is the subject matter of solicitation.

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