URN No. : PF/4016/01

Proposal Form No.: 4016_24022026

Proposal Form for Group Health (Floater) Insurance Policy

For Official Use Only

Agent/ Broker Name: _____ Marketing Officer: _____

Branch Address _____ Marketing Officer: _____

Group ID._____ Client ID. _____ Phone No. _____

GUIDELINES FOR COMPLETION OF THE FORM

1. Please answer all 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 voidable at the option of the 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.
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 has been paid.

SCOPE OF COVER: This Policy covers reimbursement of hospitalisation expenses incurred for diseases contracted or injuries sustained in India. Medical expenses upto 30 days for Pre- hospitalisation and upto 60 days for post - hospitalisation are also admissible.

The sum insured under this Policy for a particular Insured person and/or all the dependant members of his/her family shall be the aggregate total sum insured available to the Insured person and each dependant member of his/her family, as would be set out in the Policy.

SIGNIFICANT EXCLUSIONS: Pre Existing Diseases, Diseases contracted During First 30 Days, Cost of Spectacles / Contact Lenses, Dental Treatment, AIDS, Pregnancy and certain specified diseases during first year of the Policy. For a detailed set of exclusions, kindly consult the policy document.

EXTENSIONS: In addition certain optional extensions are available, the details of which, are provided in the relevant section of this proposal form.

NOTE: The foregoing is only an indication of the cover offered. For details, please refer to the Policy.

CLIENT INFORMATION

Proposer's Name: First Name Middle Name Last Name

Proposer's Mailing Address:

City / Town / Village

State Pin Code

Contact No. Mobile

E-Mail Address

Permanent Residence Address

Landmark

City / Town / Village

State Pin Code

Proposer's trade or business:

Particulars of Work:

Type of Proposer: ☐ Individual ☐ Partnership firm ☐ Company ☐ Govt. ☐ Others:

Constitution of Business: ☐ Non Resident Entity ☐ Foreign company registered in India ☐ Foreign LLP ☐ Government Department ☐ Hindu Undivided Family ☐ LLP Partnership ☐ Public Ltd Co ☐ Local Authorities ☐ Partnership ☐ Private Limited Company ☐ Proprietorship ☐ Others, Please Specify:

Customer Type: ☐ General ☐ EOU/STP/EHTP ☐ Government ☐ Overseas ☐ Related parties ☐ SEZ ☐ Others, Please Specify:

Annual Income: Do you file income tax return? ☐ Yes ☐ No

Do you own a bank account? ☐ Yes ☐ No

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)

Country: PAN Number:

Paid-up capital of the firm (in ₹ million)

Business Sector: ☐ Urban ☐ Rural *Registered GST : ☐ Yes ☐ No (One Policy One Invoice)

If Yes, then please provide GSTIN:

Address (Registered under GST):

One Policy Multiple Invoice: ☐ Yes ☐ No [If yes, it can be taken as an Annexure to Proposal Form as detailed below]

If Yes, then please provide:

Details of all previous Health Insurance Policies since inception (if applicable)

Name of Previous Insurer

Policy Period D D M M Y Y Y Y To D D M M Y Y Y Y

Name of the Product

Are you or any of the proposed applicants/beneficial owner a PEP* or a close relative of a PEP*? ☐ Yes ☐ No

If yes, please give details:

*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.
Note: In all above cases, complete address of the customer is required to be taken.

Details of Beneficial Owner*

Mention the details of individual persons who has/have the Beneficial Ownership in the captioned entity:

				Particular			
Sr. No.	**Full Name**	**Date of Birth**	**Nationality**	**Address**	**% Share Holding**	**PAN**	****Politically Exposed Person(PED) Declaration**
							☐ PEP ☐ Family member/ Close relatives /Associates to PEP ☐ No
							☐ PEP ☐ Family member/ Close relatives /Associates to PEP ☐ No
							☐ PEP ☐ Family member/ Close relatives /Associates to PEP ☐ No
							☐ PEP ☐ Family member/ Close relatives /Associates to PEP ☐ No

State-wise GSTIN	Address Registered under respective GSTIN

Contact Details

Contact Person's Name: First Name Middle Name Last Name

Mailing Address:

City / Town / Village

State Pin Code

Contact Number (Landline-With STD Code): Mobile

E-Mail Address

Risk Details

Please provide the list of person to be insured in the following format.

Period of Insurance: D D M M Y Y Y Y To Midnight D D M M Y Y Y Y

Number of Persons to be Insured

Sr. No.	Name of the employee/ self and dependent	Relationship with the employee/ self	Date of Birth	Age	Gender	Sum Insured (₹.)	Specify existing diseases, if any
1			DD/MM/YYYY		M/F/T		
2			DD/MM/YYYY		M/F/T		
3			DD/MM/YYYY		M/F/T		
4			DD/MM/YYYY		M/F/T		

NOMINEE DETAILS

	1st Nominee	2nd Nominee	3rd Nominee	4th Nominee
Name of Nominee				
Date of Birth of Nominee	D D M M Y Y Y Y	D D M M Y Y Y Y	D D M M Y Y Y Y	D D M M Y Y Y Y
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)

Appointee Name Relationship with Proposer

Note:

1) Please provided an additional sheet if space is not sufficient to complete details.

2) Names of the dependents should be mentioned immediately below the name of each employee.

Do all the members proposed to be insured form part of One Group or Association or Corporate body ? ☐ Yes ☐ No Kindly provide the particulars for the past 3 policy periods or less period for which policy availed, in the following format.

3) The above information is captured in the annexure.

Period of Insurance		Name & Address of the Insurer	Policy Number	Total Premium (₹)	Total Amount of claims (₹) (Paid + Outstanding)
From Date	To Date				
D D M M Y Y Y Y	D D M M Y Y Y Y				
D D M M Y Y Y Y	D D M M Y Y Y Y				
D D M M Y Y Y Y	D D M M Y Y Y Y				
D D M M Y Y Y Y	D D M M Y Y Y Y				
D D M M Y Y Y Y	D D M M Y Y Y Y				
D D M M Y Y Y Y	D D M M Y Y Y Y				

1) If you want to avail of extension of the policy by payment of additional premium, please specify

1	Maternity Benefits	☐ Yes	☐ No
2	Pre-existing Diseases	☐ Yes	☐ No
3	Reimbursement of Cost of Health Check-Up	☐ Yes	☐ No

Note: The Reimbursement of Cost of Health Check-Up Extension is only available after 4 consecutive claims free years of policy availed

2) If you want to avail of exclusion of coverage under the policy with consequent reduction of premium, please specify:

1	Domiciliary Hospitalisation	☐ Yes	☐ No
2	Pre & Post Hospitalisation Cover	☐ Yes	☐ No

Any Additional information relevant to the policy applied for

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

PAYMENT INFORMATION MODE OF PAYMENT

☐ Cheque ☐ Demand Draft ☐ Demand Draft No.

Drawn On. Dated D D M M Y Y Y Y

Bank Account No. Amount in Figures:

Amount in Words:

NOMINEE BANK ACCOUNT DETAILS

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

Account Holder Name

Bank Name Account No.

IFSC CODE MICR No.

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

DECLARATION BY PROPOSER

I/We, the undersigned hereby declare that the above statements and particulars are true, accurate and complete and I/We declare and agree that this declaration and the answers given above shall be held to be promissory and shall be the basis of the contract between me/us and the Company. I/We agree that the Company may exchange, share or part with any information to or with other ICICI Group Companies or any other person in connection with the Proposal, as may/be determined by the Company and shall not hold the Company liable for such use/application.

I/We, hereby declare, on my behalf and on the behalf of all the 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 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 the 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/proposer after the proposal has been submitted but before communication of the risk acceptance of the company.

I/We declare and consent to the company seeking medical information from any doctor or from a hospital who at anytime has attended on the life to be insured/proposer 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 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 Governmental and/or Regulatory Authority.

I hereby give my consent to the Company to verify and obtain my 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

DECLARATION BY PROPOSER

I/We hereby agree and ensure to maintain details of all the beneficiaries covered under the policy and shall share the same with Company as and when required.

Place:_____ **Date:** D D M M Y Y Y Y

Name _____

Designation : _____

Company Seal :

Client's Signature and Stamp

Authorized Signatory

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:

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 the Proposer

Name of the Witness

Signature of Proposer

Signature of Witness

Place: _____

Date D D M M Y Y Y Y

Relationship with Proposer

Address of Witness

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.

Referred by :

Agent Code : _____

Agent Name :

Sector : ☐ Urban ☐ Rural ☐ Social

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Vertical Information

Agent Name: _____ Marketing Officer: _____

Received date & time by MO. Date : D D M M Y Y Y Y Time: H H / M M

Data Sharing Format For Group Health (Floater) Policies

Insured Details		
Name of Insured/ Proposer		
Address of Insured/ Proposer		
Business of Insured/ Proposer		
Contact Person at Insured		
Phone no. and E-mail ID		
Employer-Employee relationship ☐ Yes ☐ No		
If No, specify relationship		
Intermediary Details		
Name of the Intermediary (Existing & New if applicable)		
Contact Details including E Mail ID		
TPA Details		
Name and Address		
Contact Details	Landline:	Cell:
Expiring Policy Details		
Period of Insurance and Policy Number (Inception Date and Expiry Date)		
Policy copy with terms/conditions including extensions is to be mandatorily provided by the Proposer		
Policy Type Base Policy / Top Up policy		
Premium paid at inception (exclusive of Service Tax)		
Premium deletion during the year		
Final Premium collected (exclusive of Service Tax) as on date to be Specified.		
For how many years policy has been active		
Member Details		
Expiring Year		
Basis of Premium Charging -per Family or per Member covered		
No. of Members at inception	Employee	Dependents
Addition during the year		
Deletion during the year		
Final no. of Members at expiry (With complete enrollment date)	Employee	Dependents
Renewal Year		
No of Members to be covered	Employee	Dependents (relation to be specified)
Please Specify Sum Insured required		
If Family coverage then no of Families to be covered		
Family/ Floater Sum Insured		
Claim Details as on (Date to be specified)under expiring policy	Reimbursement	Cashless
Claims paid as on date		
Claims outstanding as on date		
If OPD cover given, then mention OPD claims separately		
Details of Claims paid under Corporate Buffer Facility as on_____		
Claims Paid as on Date		
Claims Outstanding as on date		
Total claims paid during the last two policy years immediately preceding the expiring year.		
Total claims paid during the last three months of two years of policy immediately preceding to the expiring year.		
Family Details (specify wherever applicable)		
Family Definition Whether Additional Children Covered		
Whether Additional Relationships Covered, like brother / sister etc.		
Any revision required in Family definition under renewal policy - please specify if yes.		
Corporate Buffer Details required under Renewal Policy		
Per Family Maximum SI for Corporate Buffer		
Maximum Number of cases during the Policy period for Corporate Buffer if same is to be capped		

I/We here y declare, on my behalf and on behalf of all persons proposed to be insured, that the above statements , answers and/ or particulars given y 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 persons.

Date :

Place :

Signature of the Designated Official of the Insured With Name and Designation

Signature of the Intermediary or Agent With Name and Designation

URN No. : PF/4016/00 Proposal Form No.: _____

NEFT/EFT Mandate Form

(Payment through EFT Mechanism)

CORPORATE DETAILS

Group/ Network Name: First Name Middle Name Last Name

Address:

Landmark

City

State

Pincode: Pan Card No.:**

PAN Card Holder's Name:

ACCOUNT DETAILS

Bank Name: First Name Middle Name Last Name

Branch Name:

Payee Name:

MICR No.: IFSC Code:

Account Type: Full Account No.:

Name as per Bank Records:

Cancel cheque No.**:

(Please attach a blank cancelled cheque copy with payee name printed on the cheque and Pan Card Copy)

If customer name/ account no /IFSC code is not available on cancelled Cheque then NEFT mandate form with Bank Sign & seal and customer signature is mandatory.

I hereby declare that the particulars given above are correct and complete. If the transaction is delayed or not effected at all reasons of incomplete or incorrect information, I would not hold the user institution responsible.

Signature & Stamp of the Payee

Verified By
(Bank Official Stamp and Authorized Signature)

Terms and Conditions for Payments through RTGS/NEFT

1. The details provided by the Customers in the Mandate Form shall be considered as final and ICICI Lombard General Insurance Company Ltd. shall not be responsible for cross verification of any of the details provided therein.
2. The RTGS/ NEFT facility shall be effective for the respective Customer(s) within 15 days of the receipt of the Mandate Form by ICICI Lombard General Insurance Company Ltd. and/ or within such period as may be reasonably required by ICICI Lombard General Insurance Company Ltd. to activate the RTGS/ NEFT facility.
3. The Customer agrees that under the RTGS/ NEFT facility, there may be a risk of non-payment in the Account of Customer on the day of the credit of Payments due to change in the applicable regulations pertaining to RTGS/ NEFT facility or due to any other reasons without any fault/inaction/failure on part of ICICI Lombard General Insurance Company or any factor beyond the control of ICICI Lombard General Insurance Company Limited.
4. The Customer agrees to indemnify, without delay or demur, ICICI Lombard General Insurance Company Ltd. and its agents and keep ICICI Lombard General Insurance Company Ltd. and its agent indemnified harmless at all times from and against any and all claims, damages, losses, costs, and expenses (including attorney's fees) which ICICI Lombard General Insurance Company Ltd. may suffer or incur, directly or indirectly, arising from or in connection with, amongst other things, either of the aforesaid reasons stated in above clauses.
5. The Customer agrees that transaction(s) through RTGS/ NEFT facility may attract inward RTGS/ NEFT charges, which if levied by the Customer's bank, shall be borne by the Customer
6. ICICI Lombard has the absolute discretion to amend or supplement any Terms and Conditions stated herein at any time and will endeavour to give prior notice of Ten days for such changes wherever feasible for the terms and conditions to be applicable. By using the new services, or at the completion of such period, whichever is earlier, the Customer shall be deemed to have accepted the changed terms and conditions.
7. Submission of documents or bank details or any other information does not in any way, shape or form, imply or express or suggest admission of liability by the company.
8. Notices under these terms and conditions may be given in writing by delivering them by hand or e-mail or on ICICI Lombard General Insurance Company Ltd. Website www.icicilombard.com or by sending them by post to the last address of the Customer.
9. These terms and conditions will be governed by the laws of India and any legal action or proceedings arising out of these Terms and Conditions shall be initiated in the courts or tribunals at Mumbai in India.
10. I / We further undertake to refund any excess amount whether demanded by ICICI Lombard General Insurance Company Ltd. or not, which has been credited in excess to my account at any time due to any reason within 7 days of such receipt of such communication from ICICI Lombard of such excess credit or such information of excess credit coming to the knowledge of the Customer through any other source.
11. I/ We agree that my/our claim payment will be credited from the date ICICI Lombard General Insurance Company Ltd. gets confirmation from its bankers, This facility will continue unless it is revoked by any party and any issuance of relevant credit instruction from ICICI Lombard General Insurance Company Ltd. to its bankers will be valid till such instruction is complete irrespective of the fact that the notice period has expired provided such a credit request has been made by ICICI Lombard General Insurance Company Ltd. before the expiry of the notice period of the Customer.
12. Please attach a blank cancelled cheque or photocopy of a cheque for verification of the particulars provided in this regard.

Signature and Stamp of Customer

Annexure

Sr. No.	Add-Ons/ Extensions	Opted (yes/no)	Details (If any)
1	Cover for Pre-Existing Diseases		
2	Maternity Expenses		
3	Out Patient Department (OPD) Expenses		
4	Cost of Prescribed External Medical Aid		
5	Baby Day One Cover		
6	Critical Illnesses Cover		
7	Travel Expenses for Medical Treatment		
8	Dental Expenses		
9	Cover for Alternate Methods of Treatment		
10	Donor Expenses		
11	Ambulance Charges		
12	Pre and Post Hospitalisation		
13	Health Check-Up		
14	Disease-Wise Sub-Limit		
15	Domiciliary Hospitalisation		
16	Treatment Outside India		
17	Convalescence Benefit		
18	Hospital Daily Cash Allowance		
19	Cover for allied hospital charges		
20	Limit on room rent , nursing charges, consultation fees, diagnostic charges, OT charges etc		
21	Wellness & Preventive Care		
22	Proportionate deduction waiver		
23	Change of Gender treatment expenses		
24	Infertility treatment expenses		
25	External congenital anomaly cover		
26	Vaccination expenses		
27	Treatment for correction of eyesight due to refractive error		
28	Age Related Macular Degeneration cover		
29	Bereavement cover		
30	Investigation & Evaluation Expenses		
31	Oocyte Donor		
32	Autism Cover		
33	Non-medical Expenses Cover		
34	Air Ambulance		
35	Compassionate Visit		
36	Home Health care		
37	Nursing at home		
38	Hazardous or adventure sports Cover		
39	Modification of initial waiting period		
40	Modification of first year exclusion		
41	Voluntary Co-payment		
42	Loss of Pay		

Annexure

Sr. No.	Add-Ons/ Extensions	Opted (yes/no)	Details (If any)
43	Top Up Cover		
44	Enhanced Sum Insured		
45	Animal/Snake Bite Cover		
46	Voluntary Deductible (Super Top Up)		
47	Corporate Floater		
48	Reinstatement of Corporate Floater Cover		
49	Reinstatement of Sum Insured		
50	Sleep Apnoea Cover		
51	Attendant Charges Cover		
52	Advance Cancer Treatment Cover		
53	Miscellaneous Buffer		
54	Second Opinion		
55	Two hour hospitalization		
56	In-patient hospitalization for Surrogacy		
57	PPN Advantage		
58	Accident Care		