ICICI Lombard
Nibhaye Vaade

ENROLLMENT FORM GROUP HEALTH ASSURE SUPER TOP UP

☐ I hereby consent to avail the Group Health Assure Super Top Up (UIN ICIHLGP22205V032122) underwritten by ICICI Lombard General Insurance Company Limited ("ICICI Lombard"). I confirm that the information furnished by me in my operative account and this enrollment form together shall constitute the proposal documents for the Group Health Assure Super Top Up Policy. Master Policy No. ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

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

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 enrolment form. Please disclose all material facts while filing in the enrolment form.

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 enrolment form/personal statement, declaration and connected documents or any material information having been withheld by the Applicant or any one acting on his behalf.

Terms and Conditions

- Initial waiting period of 30 days for all illnesses (except Hospitalisation due to injury or accident).
- The liability of the insurer does not commence until this enrollment form has been accepted by the insurer and premium realized.
- Declared & accepted Pre-existing diseases will be covered after 36 months waiting period.
- Specified disease/procedure waiting period of 36 months is applicable.
- Premium at the time of renewal is subject to change in case of addition or deletion of the insured member and/ or basis change in age band of eldest insured member.
- The Insured person may have to undergo pre policy medical checkup at our designated network provider/ service provider depending upon his/her age and SI opted. The insurer will bear 100% of the expenses incurred on the acceptance of the proposal. In case the proposal is not accepted, the premium shall be refunded post deduction of the expenses incurred for the medical tests.

APPLICANT / CUSTOMER INFORMATION

Please fill all the particulars in CAPITAL letters only

Applicant Name (please leave a space after each part of name)

Mr. / Ms. / Dr.: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

DETAILS OF PERSONS TO BE INSURED

Insured No.	Full Name (First, Middle, Last)	Gender (M/F/T)	Date of Birth (DD/MM/YY)	Relationship with Applicant	Height (feet / inch)	Weight (kgs)	Sum Insured	ABHA 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					

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

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.

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

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 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

DETAILS OF THE INSURANCE COVER

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.

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 THE INSURANCE PRODUCT/ PLANS

Please fill the form as per your health care needs.

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

MEDICAL AND LIFESTYLE INFORMATION

Has the person proposed to be insured ever suffered from / is suffering from any of the following. Kindly check (✓) the relevant box wherever applicable as per Insured and Pre-existing condition.

		Insured 1	Insured 2	Insured 3	Insured 4
1	Hypertension High Blood pressure History				
2	Diabetes Mellitus Sugar History				
3	Hyperlipidemia Cholesterol History				
4	Does any person proposed to be insured smoke or consume Tobacco in any form or alcohol				
5	Heart and Circulatory Conditions or Disorders chest pain angina palpitations congestive heart failure coronary artery disease heart attack bypass surgery or angioplasty valve disorder or replacement pacemaker insertion rheumatic fever congenital heart condition varicose veins clots in veins or arteries blood disorders anti coagulant therapy etc				
6	Urinary Conditions or Disorders Blood in urine increase in urinary frequency painful or difficult urination Kidney and or Bladder infections stones of urinary system kidney failure dialysis or Any Other Kidney or Urinary Tract Or Prostate Disease				
7	Musculoskeletal Conditions or Disorders Joint or back pain Arthritis Spondylosis Spondylitis SPinal disorders Surgeries Osteoporosis Osteomyelitis Joint Replacement Or Any Other Disorder of Muscle or Bone or Joint or ligaments tendons or discs gout herniated disc fractures or accidents or implants amputation or prosthesis Muscle weakness Polio etc				
8	Respiratory Conditions or Disorders Shortness or difficulty of breath Tuberculosis Asthma Bronchitis Chronic Obstructive Pulmonary Disease COPD chronic cough coughing of blood etc or any Other Lung or Respiratory Disease				
9	Digestive Conditions or Disorders Jaundice chronic diarrhea intestinal bleeding or problems or polyps diseases of the pancreas liver or gall bladder hepatitis A or B or C or other jaundice Ulcerative colitis Chrons disease Inflammatory or irritable bowel disease Cirrhosis unexplained weight loss or gain eating disorder or any Other Gastro Intestinal condition				

		Insured 1	Insured 2	Insured 3	Insured 4
10	Cancer or Tumor Benign Or Malignant tumor Any Growth or Cyst any Cancer diagnosed earlier and or treatment taken for cancer				
11	Brain or Nervous System or Mental or Psychiatric Conditions or Developmental Disorders or Congenital or Birth defect Loss of consciousness fainting dizziness numbness or tingling weakness paralysis head injury stroke migraine headaches or chronic severe headaches sleep apnea multiple sclerosis seizures or epilepsy or any Other Brain or Nervous System Disease Mental or Psychiatric disorder ADHD autism disability or deformity whether physical or mental etc				
12	Female Reproductive Conditionsor Disorders Pelvic pain abnormal menstrual bleeding abnormal PAP smear endometriosis Fibroid Cyst or Fibroadenoma Bleeding Disorder Pelvic infection Or Any Other Gynecological or Breast cysts or lumps or tumor				
13	Eye Ear Nose and Throat Disorders Cataract glaucoma Opticneuritis retinal detachment conjunctivitis squint ptosis Blindness refractive error or 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				
14	Sexually Transmitted Diseases HIV or AIDS immunodeficiency or any venereal disease VD or sexually transmitted disease STD				
15	Metabolic Endocrine Conditions or Disorders and autoimmune or genetic disorder Adrenal or pituitary disorders thyroid disorder lupus scleroderma thyroid disorders Thallasemia anemia Hemophillia Obesity and related surgeries etc				
16	Is any female member pregnant tested positive with a home pregnancy test or ectopic pregnancy infertility treatment				
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				
18	Has any member consulted with or received treatment from any doctor or other health care provider for any other condition or symptoms or undergone any hospitalization or illness or surgery or currently taking medications for any condition or medical procedures including diagnostic testing				
19	Does the individual have a family history of any disease like Heart disease or brain disease or cancer or organ failure or autoimmune or genetic disorder				

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 i 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

DECLARATION

I hereby give my consent to the company to contact me for health and related services.

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 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 further declare that I will notify in writing any change occurring in my occupation or general health after the proposal has been submitted but before communication of the risk acceptance by the insurer.

I declare and consent to the insurer seeking medical information from any doctor or from a hospital who has attended to my health or from any past or present employer concerning anything which affects my physical or mental health and seeking information from any insurance company to which an application for insurance has been made by me for the purpose of underwriting the proposal and/ or claim settlement.

I authorise the insurer 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 hereby give my consent to enroll me into Health Shield 360 Insurance Policy underwritten by ICICI Lombard General Insurance Co. Ltd. (IRDA Reg No 115)

I 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.

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.

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, not later than 30 days.

In case any of the above information is found to be false or untrue or misleading or misrepresenting, I am/we are aware that I/we may be held liable for it.

Signature of the Applicant/ Customer: _____ Place: _____ Date: __ __ / __ __ / __ __ __ __

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: _____