Buy / Renew / Service / Claim related queries
Log on to www.icicilombard.com or call 1800 2666

Enrolment form No._____

# PROPOSAL FORM - GROUP HOSPI-SHIELD PLUS

**FOR OFFICIAL USE ONLY**

URN No.: PF/4154/00 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/Group Administrator (organization/institute/association):

Permanent Address of Proposer/Group Administrator:

Landmark:

City/Town: State: Pin Code:

Mailing Address of Proposer/Group Administrator:

Landmark:

City/Town: State: Pin Code:

Nature of Group:

Mobile Number*: Type of business:

E-mail ID:

GSTIN No.: Pan No.:

Aadhar No.: Date of Incorporation: D D M M Y Y Y Y

Place of Incorporation:

Registration No. (E.g. CIN)

Status (please tick any one)

Private Limited Co. ☐ Public Ltd. Co. ☐ Unincorporated Association or Body of Individuals ☐ Partnership/LLP ☐

Trust/ Foundation ☐ Government ☐ NGO/NPO (If yes, obtain DARPAN Portal Registration No.) ☐

Others (please specify) ☐ _____

Nature of Business:

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

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.: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

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.*

Details of Beneficial Owner*

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

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

Important note:-

(*) The beneficial owner shall be determined as follows:

(a) where the client is a company, the beneficial owner is the natural person(s), who, whether acting alone or together, or through one or more juridical person, has a controlling ownership interest (more than ten percent of shares or capital or profits of the company) or who exercises control through other means

(b) where the client is a partnership firm, the beneficial owner is the natural person(s), who, whether acting alone or together, or through one or more juridical person, has ownership of/entitlement to more than ten percent of capital or profits of the partnership or who exercises control through other means

"Explanation - For the purpose of this clause, "Control" shall include the right to control the management or policy decision;"

(c) where the client is an unincorporated association or body of individuals, the beneficial owner is the natural person(s), who, whether acting alone or together, or through one or more juridical person, has ownership of or entitlement to more than fifteen percent of the property or capital or profits of such association or body of individuals

(d) where the client is a trust, the identification of beneficial owner(s) shall include identification of the author of the trust, the trustee, the beneficiaries with ten percent or more interest in the trust and any other natural person exercising ultimate effective control over the trust through a chain of control or ownership

(e) where no natural person is identified under (a) or (b) or (c) above, the beneficial owner is the relevant natural person who holds the position of senior managing official

## 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: ☐☐☐☐☐☐☐☐

## 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

## RISK DETAILS - PART B

**Period of Insurance:** From D D M M Y Y Y Y To D D M M Y Y Y Y

**Policy tenure:** Year(s) ☐☐☐☐☐ / Month(s) ☐☐ / Day(s) ☐☐ / Hour(s) ☐☐

**Type:** New ☐ Renewal ☐ (In case of renewal, please mention previous policy no. ( _____ )

**Risk Category:** Please specify percentage distribution of group members under different risk categories

**Category I** - Doctors, Lawyers, and persons engaged in clerical and administrative or similar job profiles _____%

**Category II** - Builders, Contractors, on site engineers, workers, Mechanics, Driver & manual laborers or similar job profile _____%

**Category III** - Persons working in mines, explosive units, electrical installations on line, Racing, Circus, Skiing, Mountaineering, Ballooning, Winter Sports & Polo or similar job profile ____%

Expected number of persons to be insured in the group: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

**Tentative Age Mix and SI mix of prospective group:** ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

| Age (in years) | Percentage distribution |
|---|---|
| 18-25 | |
| 26-40 | |
| 41-50 | |
| 51-65 | |
| >65 | |

On duty coverage: ☐ Yes ☐ No

Defined/Restricted Geographical Cover: ☐ Yes ☐ No If Yes, please share details _____

## TABLE OF BENEFITS - PART C

| Section | Cover Name Coverage | Required (Y/N) | Additional Details |
|---|---|---|---|
| **SECTION A** (Base Covers) | Hospital Daily Cash Benefit | ☐Y ☐N | |
| | EMI benefit | ☐Y ☐N | |
| | Daycare Benefit | ☐Y ☐N | |
| | Cancer Cash Benefit | ☐Y ☐N | |
| **SECTION A** (Extension Covers) | ICU Benefit | ☐Y ☐N | |
| | Brain & Stroke Hospitalization Cash Benefit | ☐Y ☐N | |
| | Organ Transplant Hospitalization Cash Benefit | ☐Y ☐N | |
| | Heart Ailment Hospitalization Cash Benefit | ☐Y ☐N | |
| | Fracture & Burns Cash Benefit | ☐Y ☐N | |
| | Ambulance Cover Benefit | ☐Y ☐N | |
| | Child Care Cash Benefit | ☐Y ☐N | |
| | Hospital Attendant Cash Benefit | ☐Y ☐N | |
| | Compassionate Visit Cash Benefit | ☐Y ☐N | |
| **SECTION B** (Base Cover) | Specific Vector Borne Hospitalization Benefit | ☐Y ☐N | |
| | Rabies & Tetanus related Hospitalization Benefit | ☐Y ☐N | |
| | Specific Gastrointestinal Infections related Hospitalization Benefit | ☐Y ☐N | |
| | Specific Viral Infections related Hospitalization Benefit | ☐Y ☐N | |
| | Specific Nervous System realed Infections related Hospitalization Benefit | ☐Y ☐N | |
| | Other Specific Disease related hospitalization | ☐Y ☐N | |
| **SECTION C** (Base Covers) | Accidental Death Benefit | ☐Y ☐N | |
| | Permanent Total Disablement (PTD) Benefit | ☐Y ☐N | |
| | Permanent Partial Disablement (PPD) Benefit | ☐Y ☐N | |
| | Temporary Total Disablement (TTD) Benefit | ☐Y ☐N | |
| | Accidental Hospitalization Expenses Benefit | ☐Y ☐N | |
| | Accidental Hospitalization Daily Cash Benefit | ☐Y ☐N | |
| | Children's Education Grant Benefit | ☐Y ☐N | |
| | Recovery Benefit | ☐Y ☐N | |
| | Loss of Job Benefit | ☐Y ☐N | |
| **SECTION C** (Extension Covers) | Repatriation of Mortal Remains due to Accidental Death | ☐Y ☐N | |
| | Memorial Expenses coverage (In event of Unfortunate Accidental Death) | ☐Y ☐N | |
| | Prosthetics/Artifical Limbs/Hearing Aids coverage | ☐Y ☐N | |
| | House and Vehicle Modification in case of Disability | ☐Y ☐N | |

## 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 ☐☐☐

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.

6. I have been provided with the detail terms of the policy. I have read, understood and aware of the details terms of the policy.
7. I declare that the contents of this proposal form and other documents have been fully explained to me and I have fully understood the significance of the proposed contract.
8. I hereby give consent for receiving proposal form and policy copy in electronic form only and to not receive the physical copy of the same.
9. I hereby confirm that I have insurable interest in the policy and the premium is not borne by any third-party entity or person.
10. I declare to having no objection to receiving relevant information pertaining to my policy/claims/renewal/servicing on messaging platforms such as Whatsapp etc.
11. 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
12. 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.
13. 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 .
14. 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.
15. 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.
16. I/We understand that the Company has right to call for documents to establish source of funds.

Name

Date D D M M Y Y Y Y Place

Designation

Proposer's Signature

## 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:

## 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: