Enrolment form No._____

PROPOSAL FORM - GROUP HOSPITAL CASH

The Policy does not commence until the proposal is accepted by the Company and full premium is paid.

CUSTOMER INFORMATION - PART A

Name of the Proposer (Name of the Corporate):

Permanent Address of Proposer:

Landmark:

City/Town: State: Pin Code:

Mailing Address of Proposer:

Landmark:

City/Town: State: Pin Code:

Mobile Number*: Pan No.:

E-mail ID:

Date of Incorporation: D D M M Y Y Y Y Registration No. (E.g. CIN)

Place of Incorporation:

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:

Plan Type Individual EI Family Floater EI

Proposed Policy Period From D D M M Y Y Y Y To D D M M Y Y Y Y

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.

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.:

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 ☐ 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

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

PROPOSED INSURED(S) DETAILS: Name of the persons proposed to be insured (including Proposer)

Sr. No.	Name of the Family Member	Relationship with the employee	Date of Birth	Gender	UID Aadhar No.	Nominee Name and Relationship	ABHA No.	Whether suffering from any pre-existing condition /disease/injury? If so, the details

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.

*Kindly attach separate sheet if required.

Name of the Nominee and relationship

In the event of t he death of an In sured Person any payment due under the Policy will be payable to the Nominee in accordance with the Policy terms and condit ions. Please give below the detai ls of the Nominee, who must be an immediate relative of the Proposer.

Nominee fora ll other persons proposed to be insured shall be the Proposer.

Nominee Name	Relationship to the Proposer	Address of the Nominee

COVERAGE DETAILS - PART B

Sr. No.	Section	Sum Insured	Benefit Period	Deductible	Franchise
1.	Hospital Daily Cash				
2.	Enhanced Hospital Daily Cash (Accident)				
3	Enhanced ICU Benefit				
4.	Enhanced Benefit (Day Care Treatment)				
5	Parents Accommodation				
6	Convalescence Benefit				
7.	Pre/Post Hospitalization Expenses				
8	Trans ortation of Mortal Remains & Funeral Ex enses				
9	Home and Vehicle Modification				
10.	Ambulance Cost				
11	External Aids & A liances				
12.	Reduced Allowance (Minor & Senior Citi zens) 13 Joint Accidental Hospita lization Reduced Al lowance (Minor & Senior Citizens				
13.	Joint Accidental Hospitalization				

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 ☐☐☐

DECLARATION

1. I/We decla re and consent ta the company seeking medical information from any doctor or from a hospital w ho at any time has attended on the life to be insured/proposer of 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 on application from insurance on the life to be assured/proposer has been made far the purpose of underwriting th e proposal and/ or cla im settlement.
2. 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.
3. I /We understand th e information provided by me will form the basis of insura nce Policy, is subject to the Boord approved underwriting policy of the insurance compa ny and that the Policy will come into farce onlyafterfull receipt of the premium chargeable.
4. I/We further declare that I/We notify in writing any change occurring in the occupation or general health of the life to be insured/ propose ofter the proposa l hos been submitted but before communicotion of the risk acceptance by the company.
5. I/We authorize the company ta shore 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.
6. I/We hereby give my/our consent to the Company to verify and obtain my/ou r 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.
7. 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.
8. I/We hereby agree and ensure to maintain details of all the beneficiaries covered under the policy and shall shore the some with Company as and when required.
9. I/We hereby declare that the details furnished above ore true and correct to the best of my/our know ledge and belief and I/we undertake to inform you of ony changes therein. immediately and not later than 30 days.
10. In case any of the above in formation is found to be false or untrue or misleading or misrepresenting, I/We am/ore aware that I/We may be held liable for it. Further, the Company hos a right to cancel the insurance cont ract in case, I am/have been found guilty by any competent court of law under any statutes, direct ly or indirectly governing the prevention of money laundering.
11. I/We understand thatthe Company has right to call for documents to establish source of funds.

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

Authorization for Electronic Policy fulfilment and service communication

☐ I /We would like to protect my environment and would like to help save paper by authorizing ICICI Lombard General Insurance Company Ltd to send all my Policy and service re lated communicat ion to the email ID as mentioned here in the applica tion form.

☐ Yes ☐ No

(Note : Please tick this option if you wish to receive your Policy at the e-mail address mentioned by you in this proposal form)

☐ I hereby consent to and authorize ICICI Lombard General Insurance Company Ltd to make welcome calls, service ca lls or any other communication (electronic or otherwise) with respect to the proposed or existing Policy of Company from time to time.

☐ Yes ☐ No

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:

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.]

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: