Enrolment form No._____

PROPOSAL FORM - GROUP SAFEGUARD MICRO INSURANCE

FOR OFFICIAL USE ONLY

URN No.: PF/4152/01

MO EMP ID ☐☐☐☐☐☐☐☐☐☐☐☐☐☐ 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): ☐☐☐☐☐☐☐☐☐☐☐☐☐☐

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

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 ☐ 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

RISK DETAILS - PART B

Period of Insurance: From D D M M Y Y Y Y To Midnight of 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. (_____)

Note:

1) Please attach a separate sheet if space available is not sufficient for filling in complete details.
2) Names of the dependants should be mentioned immediately below the name of each employee

Do al l the members proposed to be insured form part of One Group or Association or Corporate Body? ☐ Yes ☐ 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	

Age (in years)	Percentage distribution
51-65	
>65	

On duty coverage: ☐ Yes ☐ No

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

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

SCOPE OF COVER - PART C

The Policy offers coverage against multiple risks such as accidental injury, animal, insect & reptile attack, specific vector borne disease or malaria, specific maternal complications and hospital daily cash cover, as opted by the proposer. For complete details on coverage, please refer to the Policy wordings.

TABLE OF BENEFITS - PART D

The Policy offers coverage against multiple health risks by providing hospital daily cash cover, outpatient cover and wellness covers, as opted by the proposer. For complete details on coverage, please refer to the Policy wordings.

Section and Benefits	Base/ Extension	Tick, for availing coverage	Additional Details (If any)
SECTION - A (Accidental Injury Benefits)			
Subsection A.1: Death & Disability Related Benefits			
Death Benefit	Base	☐	
Permanent Total Disablement (PTO) Benefit	Base	☐	
Permanent Partial Disablement (PPD) Benefit	Base	☐	
Temporary Total Disablement (TTD) Benefit	Base	☐	
Common Carrier Accident Benefit	Base	☐	Out-Station Bus/ Out-Station Taxi / Charter Airline/ Helicopter / Cruise/ Ship/ Commercial Licensed Airline/ Suburban Trains/ Long route Trains/ City Cabs/ City Buses
Adventure Sports Benefit Base	Base	☐	
Children's Education Grant Benefit Base	Base	☐	
EMI Benefit Base	Base	☐	No. of EM Is opted
Loan protection Benefit	Base	☐	
Mobility Benefit	Extension	☐	
Orphan Benefit	Base	☐	
Repatriat ion of Mortal Remains Benefit	Extension	☐	
Counselling Benefit	Extension	☐	
Parental care Benefit	Base	☐	
Repatriation in case of Permanent Disability Benefit	Extension	☐	
Subsection A.2: Hospitalization Expenses Related Benefits			
Accidental Hospita lization Expenses Reimbursement Benefit	Base	☐	Deductible ☐ / Franchise ☐ • Days _____ • Sum Insured ₹ _____
Accidental Pre & Post Hospitalization Expenses Benefit	Extension	☐	Not Applicable
Accidental Hospitalization Daily Cash Benefit	Base	☐	Not Applicable
Air Ambulance Benefit	Extension	☐	Not Applicable
Comatose Benefit	Extension	☐	

Broken Bones Benefit	Extension		
Compassionate Visit Benefit	Extension		
Burns Benefit	Extension		
Ambulance Charges Benefit	Extension		
Subsection A.3: Other Benefits			
Assault Benefit	Extension		
Mysterious Disappearance Benefit	Extension		
Section B (Animal, Insect & Reptile Attack Benefit)			
Death due to Animal, Insect and Reptile Attack Benefit	Base		
Permanent Total Disablement (PTO) due to Animal, Insect and Reptile Attack Benefit	Base		
Hospitalization Expenses due to Animal, Insect & Reptile Attack Reimbursement Benefit	Extension		
Section C (Specific Vector Borne Disease or Malaria Benefit)			
Sub section C.1: Specific Vector Borne Disease Benefit			
Specific Vector Borne Disease related Hospitalization Benefit	Base		
Sub section C.2: Malaria Benefit			
Malaria related Hospitalization Benefit	Base		
Section D (Maternal Complication Benefit)			
Maternal Complication Benefit	Base		
Section E (Hospital Daily Cash Benefit - Illness)			
Hospital Daily Cash Benefit	Base		Deductible / Franchise Days
Intensive Care Unit (ICU) Cash Benefit	Extension		Deductible / Franchise Days
Emergency Medical Services Benefit	Base		
Waiting period waiver Yes No	If No, Waiting Period - Days		

PREMIUM DETAILS - PART E

(Applicable for non-contributory policy)

Premium Amount: ₹ DD /Cheque Amount:

Amount: ₹ DD/Cheque No.

In case of NEFT please specify NEFT details: Issuing Bank Name:

Bank Name:

Premium Payment Frequency: Lumpsum Yearly Half-Yearly Monthly

CLAIM EXPERIENCE/PREVIOUS POLICY DETAILS

Please share details of previous polices and claims(If any) in the past under Universal Protection with Us or any policy with similar covers with Us or any other insurer in the past. **If yes, please provide details as below:**

Policy Period (From and To)	Name and address of insurer	Policy number	Premium paid	Total claim amount (₹)	Claim Details
From D D M M Y Y Y Y To D D M M Y Y Y Y					
From D D M M Y Y Y Y To D D M M Y Y Y Y					

From D D M M Y Y Y Y To D D M M Y Y Y Y					

Note: Please attach a separate sheet if space available is not sufficient for filling in complete details.
Any additional information material to assumption of risk

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

Policy Period Name of the product

DECLARATION - PART G

1. I hereby declare, on my behalf and on behalf of all persons proposed to be insured, that the above statements, answers and/or part iculars given by me are true and complete in all respects to the best of my knowledge and that I am authorised to propose on behalf of these other persons.
2. I understand that the information provided by me w ill fo rm the basis of the insurance policy, is subject to the Board approved underwriting policy of the insurer and that the policy w ill come into force only after fu ll payment of the premium chargeable.
3. I further declare t hat I will notify in writ ing any change occurring in the occ upation or genera l hea lth of the life to be insured/proposer after the proposa l has been submitted but before communica tion of the risk acceptance by the company.
4. I declare that I consent to the company seeking medical informa tion from any doctor or hospi tal w ho/which at any time has attended on the person to be insured/proposer or from any past or present employer concerning anything which affects the physical or mental health of the person to be insured/proposer and seeking information from any insurer to w hom an application for insurance on the person to be insured /proposer has been made for the purpose of underwriting the proposal and/or claim settlement.
5. I authorize the company to share information pert ai ning to my pro posal including the medical records of the insured/proposer for the sole pu rpose of underwriting the proposal and/or claims settlement and with any Governmental and/or Regu latory authority.
6. 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
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 have been provided with the detail terms of the policy. I have read, understood and aware of the detai ls terms of the policy.
9. I declare that the contents of this proposal form and other documents have been fu lly explained to me and I hove fu lly understood the significance of the preposed contract.
10. I hereby give consent for receiving proposal form and policy copy in electronic form only and to not receive the physical copy of th e same.
11. I hereby confirm that I have insurable interest in the policy and the premium is not borne by any third party entity or person.
12. 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.
13. I/We hereby declare that the details furn ished 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.
14. 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 cont ract in case. I am/have been fou nd guilty by any competent court of law under any statutes, direct ly or indirectly governing th e prevention of money laundering.
15. I/We understand that the Company has right to co ll for documents to establi sh 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: