HEALTH CARE PLUS INSURANCE PROPOSAL FORM

UIN No:ICIHLGP21390V032021

For Official Use Only

Product Code: Proposal No. : Code/Functional Identity:

Intermediary Name & Specified Person Name / Principal Officer Name:

Branch/Office: Deal No.:

Email ID of the branch: Contact No. of the branch:

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

Please answer all the questions fully and correctly. Where any question does not apply, please mention clearly that the same is not applicable.

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. Please disclose all material facts while filing in the proposal 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 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. Kindly contact the Company's Offices or Agents for any doubts or clarifications on the proposal form.

Terms and Conditions

- Initial waiting period of 30 days for all illnesses (except Hospitalization due to injury or Accident)
- Specific waiting period of first two years for specific illnesses and treatments (mentioned in the policy wording)
- Pre- existing conditions/ diseases declared and accepted by Us will be covered immediately after 2 years of continuous coverage under the policy
- Sum Insured can be changed at the time of renewal only. Company reserves right to approve/ reject the change in Sum Insured. Fresh waiting period as per the terms of the policy will be applicable to the enhanced limit from the effective date of such enhancement.
- Factors determining the renewal premium are (i) age slab of the senior most insured member at the time of renewal (ii) any change in the renewing policy.
- The liability of the Company does not commence until this Proposal has been accepted by the Company and premium realised.
- Please note that the renewal premiums are subject to change based on the age of the insured person.
- The premium amount may change based on the medical underwriter's decision.

Signature of proposer/ customer: Date: D D / M M / Y Y Y Y Place:

PROPOSER / CUSTOMER INFORMATION

Please fill all the particulars in CAPITAL letters only

Proposer's Name (please leave a space after each part of name)

Mr./ Ms./ Dr./ Mx. : F I R S T M I D D L E L A S T

Date of Birth : D D / M M / Y Y Y Y Gender : Male Female Transgender Marital Status : Single Married

Occupation :Salaried Self Employed Professional Others Details

Occupation and Nature of Business/Work:

Nationality: Indian Others (please specify) Residential Status: Indian Resident Non Resident Indian

Educational Qualifications: Lesser than matriculation Matriculation Graduate Post-graduate Professional Course

Annual Income : Less than 5 Lacs Between 5 - 10 Lacs Between 10 - 20 Lacs 20 Lacs and above

GST Number: (If Applicable) Aadhaar No.

PAN Card No.: CKYC/Driving License/Aadhaar/Election Card/Passport/MNREGA Card No.

Correspondence Address : Landmark :

City : State : Pin code :

Landline Number (with STD Code) : Mobile Number* :

E-mail address :

Permanent Residence Address : Landmark :

City : State : Pin code :

Are you or any of the proposed applicants 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.*

*Kindly provide the details to enable us to serve you better

NOMINEE DETAILS

	1st Nominee	2nd Nominee	3rd Nominee	4th Nominee
Name of Nominee				
Date of Birth of Nominee	DD/MM/YYYY	DD/MM/YYYY	DD/MM/YYYY	DD/MM/YYYY
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 :

FAMILY PHYSICIAN DETAILS

Name of Physician : F I R S T M I D D L E L A S T

Landline Number (with STD Code) : Mobile Number :

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 Proposer	Height (feet / inch)	Weight (kgs)	PAN No.	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					
5.			D D / M M / Y Y Y Y					

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.

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

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 ☐

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.

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

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.

Name of Insurer

Policy Period Name of the product

Policy number Sum Insured Other details

DETAILS OF THE INSURANCE PRODUCT/ PLANS

Please fill the form as per your health care needs.

Health Care Plus Insurance

Tenure	☐ 1 Year ☐ 2 Year	Age Band	☐ 5 - 65* Years	No. of Individuals	☐ 1 ☐ 2 ☐ 3 ☐ 4
Sum Insured	☐ 5 Lacs; Deductible 2 lacs		☐ 8 lacs; Deductible 3 lacs		☐ 10 lacs; Deductible 4 lacs

* Medical report required for person aged 56 years and above. All family members to have same policy tenure and plan.

Do you wish to avail a physical copy of your policy docum☐ts? ☐s No

PAYMENT DETAILS

Payment Option: Cheque ☐ DD ☐ Cheque/DD Number: Dated: D D / M M / Y Y Y Y

Premium Amount: Amount in words:

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

☐ Yes, I would like to opt for ECS Payment option for Policy Renewal.

I/we hereby declare and undertake that the amount paid by me/us as premium for the aforementioned policy is out of my/our lawful and declared source of income

Signature of the proposer/customer: Place: Date: D D / M M / Y Y Y Y

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

☐ Yes, I would like to opt for ECS Payment option for Policy Renewal.

I/we hereby declare and undertake that the amount paid by me/us as premium for the aforementioned policy is out of my/our lawful and declared source of income

Signature of the proposer/customer: Place: Date: D D / M M / Y Y Y Y

MEDICAL AND LIFESTYLE INFORMATION

SECTION A: Have any of the person proposed to be insured ever suffered from / are suffering from any of the following: Please tick 'YES" for insured wherever applicable and provide details in Section B

	Yes/ No	Insured 1	Insured 2	Insured 3	Insured 4	Insured 5
1. Hypertension History :	Y N					
a) Duration						
b) Medications						
c) Dosage						
2. Diabetes Mellitus History :						
a) Type I or Type 2	Y N					
b) Duration						
c) Medications						
d) Dosage						

	Yes/ No	Insured No
3. **Heart and Circulatory Conditions/Disorders:** chest pain, angina, high cholesterol/lipids, palpitations, congestive heart failure, coronary artery disease, heart attack, bypass surgery/angioplasty, valve disorder/replacement, pacemaker insertion, rheumatic fever, congenital heart condition, varicose veins, thrombosis, blood disorders etc.?	Y N	1 2 3 4 5
4. **Urinary Conditions/Disorders:** Blood in urine, urinary frequency, painful/difficult urination Kidney and/or Bladder infections, stones of urinary system, renal failure, dialysis or Any Other Kidney/Urinary Tract Or Prostate Disease	Y N	1 2 3 4 5
5. **Musculoskeletal Conditions/Disorders:** Joint/back pain Arthritis, Spondylosis, Joint Replacement Or Any Other Disorder of Muscle/ Bone/ Joint/ ligaments, tendons or discs, gout, herniated disc, amputation/prosthesis	Y N	1 2 3 4 5
6. **Respiratory Conditions/Disorders:** Shortness/difficulty of breath, Tuberculosis, Asthma, Bronchitis, Chronic Obstructive Pulmonary Disease COPD, chronic cough , coughing of blood, etc or any Other Lung / Respiratory Disease	Y N	1 2 3 4 5
7. **Digestive Conditions/Disorders:** Jaundice, chronic diarrhea, intestinal bleeding/problems/polyps, diseases of the pancreas, liver or gall bladder, hepatitis A/B/C/other, jaundice, Cirrhosis, unexplained weight loss or gain, eating disorder or any Other Gastro Intestinal condition	Y N	1 2 3 4 5
8. **Cancer/Tumor -** Benign Or Malignant tumor, Any Growth/Cyst, any Cancer	Y N	1 2 3 4 5
9. **Brain/Nervous System/ Psychiatric Conditions/Disorders:** Loss of consciousness, fainting, dizziness, numbness/tingling, weakness, paralysis, head injury, stroke, migraine headaches or chronic severe headaches, sleep apnea, multiple sclerosis, seizures/epilepsy or any Other Brain/ Nervous System Disease, Mental/Psychiatric disorder	Y N	1 2 3 4 5
10. **Female Reproductive Conditions/Disorders:** Pelvic pain, abnormal, menstrual bleeding abnormal PAP smear, endometriosis, Fibroid, Cyst/ Fibroadenoma, Bleeding Disorder, Pelvic infection Or Any Other Gynecological / Breast cysts/lumps/tumor	Y N	1 2 3 4 5
11. Is any female member pregnant, tested positive with a home pregnancy test, or in the process of adoption or becoming a surrogate?	Y N	1 2 3 4 5
12. **Metabolic and Endocrine Conditions/Disorders:** Adrenal/pituitary disorders, thyroid disorder, lupus, scleroderma, thyroid disorders, any autoimmune/genetic disorder	Y N	1 2 3 4 5
13. Does the person proposed to be insured suffer from any chronic or long-term medical condition, or have any other disability, abnormality or recurrent illnes or injury or unable to perform normal activities?	Y N	1 2 3 4 5
14. Does the person proposed to be insured use tobacco products/cigarettes or drinks alcohol?	Y N	1 2 3 4 5
15. Has any member consulted with or received treatment from any doctor or other health care provider for any other condition or symptom(s)/undergone any hospitalization/illness/surgery/ currently taking medication(s) for any condition or medical procedures (including diagnostic testing)	Y N	1 2 3 4 5
16. Have you or any of the persons proposed for Insurance been diagnosed with or undergone surgery for any of the following Critical Illnesses, prior to proposing for this cover - Cancer, Heart Attack, Coronory Artery, Bypass Graft, Heart Valve Replacement/ Repair, Coma, Kidney Failure, Stroke, any Transplant, Paralysis, Multiple Sclerosis, Motor Neurone Disease	Y N	1 2 3 4 5

DEBIT MANDATE FORM NACH / ECS / DIRECT DEBIT

Proposal No. T/042016-17 **Product Code:** 4113

To,
ICICI Lombard General Insurance Company Ltd., ICICI Lombard House, 414, Veer Savarkar Marg, Near Siddhi Vinayak Temple, Prabhadevi, Mumbai 400 025.
Ref : Authorization of Customer to remit funds/payments to ICICI Bank Ltd through Electronic Clearing Service

(tick ✓) CREATE / MODIFY / CANCEL

UMRN: Date: D D / M M / Y Y Y Y

Sponsor Bank Code: Utility Code:

I/We hereby authorize to debit (tick ✓) SB / CA / CC / SB-NRE / SB-NRO / Other

Bank a/c Number:

Account Holder Name

with Bank IFSC: or MICR:

an amount of ₹ ₹

Frequency: Mthly Qtly H-Yrly Yrly As & when presented **Debit Type:** Fixed Amount Maximum Amount

Reference 1 Phone No.:

Reference 2 Email ID:

Period: From: D D / M M / Y Y Y Y To D D / M M / Y Y Y Y OR Until Cancelled

Declaration:

I wish to avail the Electronic clearing facility and hereby express my unconditional consent to debit premium for my Health insurance policy applied vide proposal form no. xxxxxxxxxxx through participation in Electronic Clearing System (ECS). I, understand and agree that premium amount to be debited from my account may vary due to change in age bracket of the senior most member insured under the policy, claims history in expiring policy, change in applicable premium rates by the insurer, taxes and other statutory levies as may be applicable from time to time.

(Please refer to sales brochure for approximate premium details due to change in age applicable at the time of renewal)

I, hereby declare that the particulars given are correct and complete. I understand and accept that the transaction will be effected on the due date as opted by me in this form subject to the payment of premium on the policy (provided the day is a working day). If the transaction is delayed or not effective at all for reasons of incomplete or incorrect information, I/we would not hold the user institution responsible. I/We have read all the terms and conditions as are applicable for availing of this ECS Debit service from/through the user institution and agree to discharge the responsibility expected of me/us as a participant under the scheme.

I/We also hereby authorize representative of ICICI Lombard General Insurance Company Ltd. carrying this ECS Debit Mandate Form to get it verified and executed by my/our Bank.

SECTION B: Name and details of Illness / Medicine / Test / Surgery / Diopter grade (for questions answered as yes in SECTION A above)	Date of Last Consultation	Doctor's Name	Hospital Name & Phone No.
Insured 1 :			
Insured 2 :			
Insured 3 :			
Insured 4 :			
Insured 5 :			

IMPORTANT NOTES

1. The information that you give to us on this proposal form or in any supplementary Information form or documentation supplied by you or on your behalf will influence our decision to offer insurance and the terms upon which to offer it. Further, any policy we issue will be based on what you have communicated to us. It is therefore important that your answer are complete and accurate in all respect.
2. The question in this proposal are indicative rather then exhaustive. You must provide us with all information relevant to the risk to be insured, even if it is not the subject of a question in this proposal. If you are in any doubt as to what information should be given, you should liaise with your insurance advisor/ company.
3. Acceptance of your proposal would be subject to receipt of complete medical reports(wherever applicable), medical underwriting and realization of full premium amount by the company and the insurance coverage will commence from the date of underwriting by the company.
4. The list of exclusions/ inclusions and other policy details are indicative, for complete list and comprehensive details kindly refer policy wordings.
5. The Policy shall become voidable at the option of the Company, in the event of any untrue or incorrect statement, misrepresentation, non- description or non-disclosure of material particulars in the Proposal Form/ personal statement, declaration and connected documents, or any material fact* information has been withheld by beneficiary or anyone acting on beneficiary's behalf to obtain insurance.

**A material fact will mean and include all important, essential and relevant information, pertaining to the questions made in this proposal form, that are likely to influence company's acceptance or assessment of the proposal.*

POLICY TERMS & CONDITIONS

Premium amount as applicable for the plan, All family members to have same policy tenure and plan.

☐ Tenure – 1 Year

Plans/No. of Individuals covered. Age Band -5 to 65 Years	No. of Individuals			
	1	2	3	4
Plan 1 : Deductible of 2 lacs; Sum Insured of 5 lacs	4,720	8,023	11,328	14,160
Plan 2 : Deductible of 3 lacs; Sum Insured of 8 lacs	3,245	5,517	7,788	9,735
Plan 3 : Deductible of 4 lacs; Sum Insured of 10 lacs	2,360	4,012	5,664	7,080

☐ Tenure – 2 Years (Auto renewal basis)

Plans/No. of Individuals covered. Age Band -5 to 65 Years	No. of Individuals			
	1	2	3	4
Plan 1 : Deductible of 2 lacs; Sum Insured of 5 lacs	8,968	15,246	21,523	26,904
Plan 2 : Deductible of 3 lacs; Sum Insured of 8 lacs	6,166	10,481	14,797	18,496
Plan 3 : Deductible of 4 lacs; Sum Insured of 10 lacs	4,484	7,622	10,761	13,452

(All prices are inclusive of GST) (All figures in INR)

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 satis es the prescribed conditions establishing that he is a bona de 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.

I, hereby authorize ICICI Lombard General Insurance Co. Ltd. and their authorized service providers, to enable the ECS facility for my premium payments and in the instance of ECS debit dishonor, to re-debit my account with the mentioned bank to recover the premium payable.

Primary Account Holder's Signature (If different from Policy Holder)

Policy Holder's Signature

Joint Account Holder's Signature 1

Joint Account Holder's Signature 2

FOR OFFICE USE ONLY

Customer ID:

Proposal No. T/042016-17 **Product Code:** 4113

For Use by Customer/Account Holder's Bank :

We hereby certify that the particulars of the customers furnished above are correct as per our records, and we hereby declare that a copy of this mandate form, duly complete and signed, has been submitted to us

Bank Stamp:

Signature of Authorized Official of the Bank

Name:

Branch:

Designation:

Date:

Disclaimer:

- Subject to change in service tax rates / re-instatement charges and as per customer's request. ICICI Lombard GIC Ltd. shall debit the customer's bank account if the customer's policy and the ECS mandate are In Force and until the customer gives a written request for cancellation of ECS.
- Request for cancellation of ECS facility has to be provided 15 days prior to the due date or the same would be effective from the next premium due date.
- Requests for payment mode to change to ECS has to be provided 30 days prior to the due date or the same would be effective from the next premium due date.
- Data provided by the customer in the cheque copy and the proposal form may be used by the Company to complete the ECS mandate in case required information has not been filled.

DECLARATION

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.

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/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/proposal after the proposal has been submitted but before communication of the risk acceptance by the company.

I/We declare and consent to the company seeking medical information from any doctor or from a hospital who at any time has attended on the life to be insured/proposed 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 be 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 Government and /or Regulatory authority.

I/We hereby give my/our consent to the Company to verify and obtain my/our identity/address proof 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 and not later than 30 days.

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.

Signature of the proposer/customer: _____ Place: _____ Date: D D / M M / Y Y Y Y

Declaration when the proposal form is filled by a person other than the proposer/ the proposer signs in a vernacular language/ proposer is illiterate

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 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: _____

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: _____