URN: PF/4177/01

Proposal Form No.: _____

PROPOSAL FORM FOR HEALTH SHIELD 360

For Official Use Only

Intermediary Name _____ Code _____

Branch Name _____ Code _____

Sales Manager's Nam _____ Code _____

GUIDELINES FOR COMPLETION OF THE FORM

1. Please answer all 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 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. If you think any fact is material, please disclose it.
3. The Policy shall become voidable at the option of the 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.
4. Kindly contact the Company's Offices or Agents for any doubts or clarifications on the proposal form.

NOTE: The liability of the Company does not commence until this proposal has been accepted by the Company and premium has been paid.

SCOPE OF COVER: This Policy covers reimbursement of hospitalisation expenses incurred for diseases contracted or injuries sustained in India. Medical expenses upto number of days specified in the Policy Schedule/Customer Information Sheet for Pre- hospitalisation and upto number of days specified in the Policy Schedule/Customer Information Sheet for post - hospitalisation are also admissible.

The sum insured under this Policy for a particular Insured person and/or all the dependant members of his/her family shall be the aggregate total sum insured available to the Insured person and each dependant member of his/her family, as would be set out in the Policy.

SIGNIFICANT EXCLUSIONS: Investigation & Evaluation, Rest cure, rehabilitation and respite care, Change-of-Gender treatments, Etc. For a detailed set of exclusions, kindly consult the policy document.

EXTENSIONS: In addition certain optional extensions are available, the details of which, are provided in the relevant section of this proposal form.

NOTE: The foregoing is only an indication of the cover offered. For details, please refer to the Policy.

CLIENT INFORMATION

Proposer's Name: _____

Proposer's Mailing Address: _____

_____

_____

City/Town: _____ State: _____ Pin Code: _____

Contact No: _____ Fax No. _____ Email ID: _____

Proposer's trade or business: _____

Particulars of Work: _____

Type of Proposer: Individual ☐ Partnership firm ☐ Company ☐ Govt. ☐ Others ☐ _____

Constitution of Business: Non Resident Entity ☐ Foreign company registered in India ☐ Foreign LLP ☐ Government Department ☐ Hindu Undivided Family ☐

LLP Partnership ☐ Local Authorities ☐ Partnership ☐ Private Limited Company ☐ Proprietorship ☐ Public Ltd Co ☐ others ☐ _____

Customer Type: General ☐ EOU/STP/EHTP ☐ Government ☐ Overseas ☐ NGO/NPO ☐ (If yes, obtain DARPAN Portal Registration number _____)

Related parties ☐ SEZ ☐ Others ☐ _____

Date of incorporation: D D / M M / Y Y Y Y Place of incorporation: _____

Nature of Business: _____

Annual Income: (In Rupess): _____ Do you file income tax return? Yes ☐ No ☐ Do you own a bank account? Yes ☐ No ☐

Country: _____ PAN Number: _____

CKYC/Driving License/Aadhaar/Election Card/Passport/MNREGA Card No _____

_____

Paid-up capital of the firm (in ₹ million) : _____ Business Sector: Urban ☐ Rural ☐

*Registered GST : Yes ☐ No ☐ (One Policy One Invoice)

If Yes, then please provide GSTIN: _____ Address (Registered under GST): _____

_____

One Policy Multiple Invoice: Yes ☐ No ☐ [If yes, it can be taken as an Annexure to Proposal Form as detailed below]

If Yes, then please provide: _____

State-wise GSTIN	Address Registered under respective GSTIN

Note: In all above cases, complete address of the customer is required to be taken.

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.

Please refer the prospectus / policy wordings and mention the optional cover which you intent to avail.

Sr. No.	Optional Cover name

Note : Annex a separate sheet if more optional covers is required.

CONTACT DETAILS

Contact Person's Name: ☐☐☐

RISK DETAILS

Period of Insurance: From: D D / M M / Y Y Y Y To: Midnight D D / M M / Y Y Y Y

Number of Persons to be insured: _ _ _ _ _

Maximum Dependent Child Age is 20 years, Opted for extension ☐ Yes ☐ No

If Yes, select the year: ☐ 25 Years ☐ or 30 Years

Please provide the list of persons to be insured in the following format.

Name of the member/ self and dependent	Relation with the member/ self	Date of Birth	Age	Gender	Sum Insured (Rs.)	Specify existing diseases, if any

Note :

1) Please provided an additional sheet if space is not sufficient to complete details.
2) Names of the dependents should be mentioned immediately below the name of each member.

Do all the members proposed to be insured form part of One Group or Association or Corporate body ?Yes ☐ No ☐

Kindly provide the particulars for the past 3 policy periods or less period for which policy availed, in the following format.

Policy Period From - To	Name & Address of the Insurer	Policy Number	Total Premium (Rs.)	Total Amount of claims (Rs.) (Paid + Outstanding)

Any Additional information relevant to the policy applied for

_____

_____

Note: Please use additional sheets if space is not sufficient to complete details.

Do you wish to avail a physical copy of your policy documents?" Yes ☐ No ☐

PAYMENT INFORMATION

MODE OF PAYMENT

☐ Cheque/ DD Cheque No.: _ _ _ _ _ _ _ _ _ _ _ _ Demand Draft No.: _ _ _ _ _ _ _ _ _ _ _ _

Drawn No.: _ _ _ _ _ _ _ _ _ _ _ _

I/We declare and consent to the company seeking medical information from any doctor or from a hospital who at anytime has attended on the life to be insured/proposer 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 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 Governmental and/or Regulatory Authority.

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 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.

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 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. Further, I/We understand that 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.

Place : _____ Date: D D / M M / Y Y Y Y

_____
Client's Signature and Stamp

Name : _____

Designation : _____

Company Seal :

_____
Authorized Signatory

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 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: _____

ICICI Lombard
Nibhaye Vaade

ICICI Lombard General Insurance Company Limited

Mailing Address: Interface Building No. 16, 601-602, 6th Floor, New Link Road, Malad (West), Mumbai - 400 064.
Registered Office Address: ICICI Lombard House, 414, Veer Savarkar Marg, Near Siddhi Vinayak Temple, Prabhadevi, Mumbai 400 025.
Visit us at www.icicilombard.com • Mail us at customersupport@icicilombard.com
Toll Free No.: **1800 2666** • Chargable No.: **+91 92236 22666** • Insurance is the subject matter of solicitation.
IRDA Reg. No. 115. • Misc 11, Misc 12 • CIN: U67200MH2000PLC129408. • UIN: ICIHLGP26051V052526.

DATA SHARING FORMAT FOR HEALTH SHIELD 360

Insured Details		
Name of Insured/ Proposer		
Address of Insured/ Proposer		
Business of Insured/ Proposer		
Contact Person at Insured		
Phone no. and E-mail ID		
If No, specify relationship		
Nominee details		
Appointee Details (In case, Minor Nominee)		
Business of Insured/ Proposer		
Contact Person at Insured		
Phone no. and E-mail ID		
If No, specify relationship		
Intermediary Details		
Name of the Intermediary (Existing & New if applicable)		
Contact Details including E Mail ID		
TPA Details		
Name and Address		
Contact Details	Landline:	Cell:
Expiring Policy Details		
Period of Insurance and Policy Number (Inception Date and Expiry Date)		
Policy copy with terms/conditions including extensions is to be mandatorily provided by the Proposer		
Policy Type Base Policy / Top Up policy		
Premium paid at inception (exclusive of Service Tax)		
Premium deletion during the year		
Final Premium collected (exclusive of Service Tax) as on date to be Specified.		
For how many years policy has been active		
Member Details		
Expiring Year		
Basis of Premium Charging -per Family or per Member covered		
No. of Members at inception	Member	Dependents
Addition during the year		
Deletion during the year		
Final no. of Members at expiry (With complete enrollment date)	Member	Dependents
Renewal Year		
No of Members to be covered	Member	Dependents (relation to be specified)
Please Specify Sum Insured required		
If Family coverage then no of Families to be covered		
Family/ Floater Sum Insured		
Claim Details as on (Date to be specified)under expiring policy	Reimbursement	Cashless

Claims paid as on date		
Claims outstanding as on date		
If OPD cover given, then mention OPD claims separately		
Details of Claims paid under Corporate Buffer Facility as on_____(		
Claims Paid as on Date		
Claims Outstanding as on date		
Total claims paid during the last two policy years immediately preceding the expiring year.		
Total claims paid during the last three months of two years of policy immediately preceding to the expiring year.		
Family Details (specify wherever applicable)		
Family Definition Whether Additional Children Covered Whether Additional Relationships Covered, like brother / sister etc.		
Any revision required in Family definition under renewal policy please specify if yes.		
Corporate Buffer Details required under Renewal Policy		
Per Family Maximum SI for Corporate Buffer		
Maximum Number of cases during the Policy period for Corporate Buffer if same is to be capped		

I/We here y declare, on my behalf and on behalf of all persons proposed to be insured, that the above statements , answers and/ or particulars given y 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 persons.

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

Place :_____

_____

Signature of the Designated Official of the Insured

With Name and Designation

_____

Signature of the Intermediary or Agent

With Name and Designation

NEFT/EFT MANDATE FORM

(Payment through EFT Mechanism)

CORPORATE DETAILS

Group/ Network Name:

Address:

Landmark:

City: State:

Pincode: Pan Card No.:**

PAN Card Holder's Name:

ACCOUNT DETAILS

Bank Name:

Branch Name:

Payee Name:

MIRC No.: IFSC Code:

Account Type: Full Account No.:

Name as per Bank Records:

Cancel cheque No.**:

(Please attach a blank cancelled cheque copy with payee name printed on the cheque and Pan Card Copy)

If customer name/ account no /IFSC code is not available on cancelled Cheque then NEFT mandate form with Bank Sign & seal and customer signature is mandatory.

I hereby declare that the particulars given above are correct and complete. If the transaction is delayed or not effected at all reasons of incomplete or incorrect information, I would not hold the user institution responsible.

Signature & Stamp of the Payee

Verified By
(Bank Official Stamp and Authorized Signature)

Terms and Conditions for Payments through RTGS/NEFT

1. The details provided by the Customers in the Mandate Form shall be considered as final and ICICI Lombard General Insurance Company Ltd. shall not be responsible for cross verification of any of the details provided therein.
2. The RTGS/ NEFT facility shall be effective for the respective Customer(s) within 15 days of the receipt of the Mandate Form by ICICI Lombard General Insurance Company Ltd. and/ or within such period as may be reasonably required by ICICI Lombard General Insurance Company Ltd. to activate the RTGS/ NEFT facility.
3. The Customer agrees that under the RTGS/ NEFT facility, there may be a risk of non-payment in the Account of Customer on the day of the credit of Payments due to change in the applicable regulations pertaining to RTGS/ NEFT facility or due to any other reasons without any fault/inaction/failure on part of ICICI Lombard General Insurance Company or any factor beyond the control of ICICI Lombard General Insurance Company Limited.
4. The Customer agrees to indemnify, without delay or demur, ICICI Lombard General Insurance Company Ltd. and its agents and keep ICICI Lombard General Insurance Company Ltd. and its agent indemnified harmless at all times from and against any and all claims, damages, losses, costs, and expenses (including attorney's fees) which ICICI Lombard General Insurance Company Ltd. may suffer or incur, directly or indirectly, arising from or in connection with, amongst other things, either of the aforesaid reasons stated in above clauses.
5. The Customer agrees that transaction(s) through RTGS/ NEFT facility may attract inward RTGS/ NEFT charges, which if levied by the Customer's bank, shall be borne by the Customer
6. ICICI Lombard has the absolute discretion to amend or supplement any Terms and Conditions stated herein at any time and will endeavour to give prior notice of Ten days for such changes wherever feasible for the terms and conditions to be applicable. By using the new services, or at the completion of such period, whichever is earlier, the Customer shall be deemed to have accepted the changed terms and conditions.
7. Submission of documents or bank details or any other information does not in any way, shape or form, imply or express or suggest admission of liability by the company.
8. Notices under these terms and conditions may be given in writing by delivering them by hand or e-mail or on ICICI Lombard General Insurance Company Ltd. Website www.icicilombard.com or by sending them by post to the last address of the Customer.
9. These terms and conditions will be governed by the laws of India and any legal action or proceedings arising out of these Terms and Conditions shall be initiated in the courts or tribunals at Mumbai in India.
10. I / We further undertake to refund any excess amount whether demanded by ICICI Lombard General Insurance Company Ltd. or not, which has been credited in excess to my account at any time due to any reason within 7 days of such receipt of such communication from ICICI Lombard of such excess credit or such information of excess credit coming to the knowledge of the Customer through any other source.
11. I/ We agree that my/our claim payment will be credited from the date ICICI Lombard General Insurance Company Ltd. gets confirmation from its bankers, This facility will continue unless it is revoked by any party and any issuance of relevant credit instruction from ICICI Lombard General Insurance Company Ltd. to its bankers will be valid till such instruction is complete irrespective of the fact that the notice period has expired provided such a credit request has been made by ICICI Lombard General Insurance Company Ltd. before the expiry of the notice period of the Customer.
12. Please attach a blank cancelled cheque or photocopy of a cheque for verification of the particulars provided in this regard.

Signature and Stamp of Customer

Nibhaye Vaade

ICICI Lombard General Insurance Company Limited

Mailing Address: Interface Building No. 16, 601-602, 6th Floor, New Link Road, Malad (West), Mumbai - 400 064.
Registered Office Address: ICICI Lombard House, 414, Veer Savarkar Marg, Near Siddhi Vinayak Temple, Prabhadevi, Mumbai 400 025.
Visit us at www.icicilombard.com • Mail us at customersupport@icicilombard.com
Toll Free No.: **1800 2666** • Chargable No.: **+91 92236 22666** • Insurance is the subject matter of solicitation.
IRDA Reg. No. 115. • CIN: U67200MH2000PLC129408. • UIN: ICIHLGP26051V052526.

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