Enrolment form No._____

PROPOSAL FORM - HOSPIFUND INSURANCE

FOR OFFICIAL USE ONLY

URN No.: PF/ 4150/01

MO EMP ID _ _ _ _ _ _ _ _ _ _ _ _ _ _ Business Sector _ Urban _ Rural _ Social

Occupation: Salaried _ Self Employed/ Business _ In case filled by an entity _ Others _ _____

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.

TERMS & CONDITIONS

- Initial Waiting Period of 30 days for all Illnesses (except Hospital ization due to Accidental injury).
- Specific Waiting Period of first two years for specific illnesses and treatments (mentioned in the policy wording).
- Pre-existing Diseases declared and accepted by Us will be covered after completion of Waiting Period of two years.
- Sum Insured can be changed at the time of Renewal only. We reserve the rigl1t to approve/reject the change in Sum Insured. Fresh Waiting Period will be applicable to the enhanced amount, from the effective date of such enhancement.

1. PROPOSER INFORMATION

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

Proposer/ Insured Person's Name: _ _ _ _ _ _ _ _ _ _ _ _ _ _

Mobile Number*: ☐☐☐☐☐☐☐☐☐☐ E-mail ID: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

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.

2. 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: ☐☐☐☐☐☐☐☐

3. FAMILY PHYSICIAN DETAILS

Name of Physician ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Disclosure:						
Pre-existing Disease(s)/ condition(s)*						
Date/Year when illness was first detected						
Treatment(s) taken for the illness along with duration for which the treatment/s/ medication was taken.						
Any hospitalization for the illness/ailment? If yes give the duration of hospitalization. If any surgery done for the illness give the name of the surgery						
Was the illness/ailment completely cured or not?						
What is the current medication for the illness?						

*Please provide details of last 10 years. Please attach an additional sheet if space provided is not sufficient to complete details.

5. COVERS OPTED

Sr. No.	Base	Yes / No	Sum Insured	Deductible/Franchise (Tick, if opted)
(i)	Hospitalization Cash Benefit	☐ Yes ☐ No	₹ __ Per day times ____ number of days. SI : ₹ _____	☐ Yes ☐ No If Yes, No. of Days:___Days
(ii)	Accidental Hospitalization Cash Benefit	☐ Yes ☐ No	₹ __ Per day times ____ number of days. SI : ₹ _____	☐ Yes ☐ No If Yes, No. of Days:___Days
Sr. No.	Base	Yes / No	Sum Insured	Deductible/Franchise (Tick, if opted)
(i)	Intensive Care Cash Benefit	☐ Yes ☐ No	₹ __ Per day times ____ number of days. SI : ₹ _____	☐ Yes ☐ No If Yes, No. of Days:___Days
(ii)	Cancer Hospitalization Cash Benefit	☐ Yes ☐ No	₹ __ Per day times ____ number of days. SI : ₹ _____	☐ Yes ☐ No If Yes, No. of Days:___Days
(iii)	Brain & Stroke Hospitalization Cash Benefit	☐ Yes ☐ No	₹ __ Per day times ____ number of days. SI : ₹ _____	☐ Yes ☐ No If Yes, No. of Days:___Days
(iv)	Organ Transplant Hospitalization Cash Benefit	☐ Yes ☐ No	₹ __ Per day times ____ number of days. SI : ₹ _____	☐ Yes ☐ No If Yes, No. of Days:___Days
(vi)	Heart Ailment Hospitalization Cash Benefit	☐ Yes ☐ No	₹ __ Per day times ____ number of days. SI : ₹ _____	☐ Yes ☐ No If Yes, No. of Days:___Days
(vi)	Fracture & Burns Cash Benefit	☐ Yes ☐ No	₹ __ Per day times ____ number of days. SI : ₹ _____	☐ Yes ☐ No If Yes, No. of Days:___Days
(vii)	Day Care Treatment Cash Benefit	☐ Yes ☐ No	₹ __ Per day times ____ number of days. SI : ₹ _____	N.A.
(viii)	Convalescence Benefit	☐ Yes ☐ No	₹ __ Per day times ____ number of days. SI : ₹ _____	N.A.
(ix)	Ambulance Cover Benefit	☐ Yes ☐ No	₹ __ Per day times ____ number of days. SI : ₹ _____	N.A.
(x)	Child Care Cash Benefit	☐ Yes ☐ No	₹ __ Per day times ____ number of days. SI : ₹ _____	☐ Yes ☐ No If Yes, No. of Days:___Days
(xi)	Hospital Attendant Cash Benefit	☐ Yes ☐ No	₹ __ Per day times ____ number of days. SI : ₹ _____	☐ Yes ☐ No If Yes, No. of Days:___Days
(xii)	Compassionate Visit Cash Benefit	☐ Yes ☐ No	₹ __ Per day times ____ number of days. SI : ₹ _____	N.A.

Please Note: It is assumed that all the Insured Person(s) mentioned in this Proposal form are opting for the same base and extension Benefits. If any Insured Person decides to opt for any other different cover, he/she should fill up an entirely new and different Proposal form.

6. PAYMENT INFORMATION

Net Premium^ (in ₹) Applicable Taxes (in ₹)

Total Premium^ (in ₹) MODE OF PAYMENT: ☐ Cheque ☐ DD ☐ NEFT

Premium Installment Payment Frequency: Lumpsum ☐ Yearly ☐ Half-Yearly ☐ Monthly ☐

Premium Payment Duration: D D M M Y Y Y Y To D D M M Y Y Y Y

Cheque No: Demand Draft No NEFT Details:

Drawn On: Dated: D D M M Y Y Y Y

Amount In Figures: Amount In Words:

7. 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

8. 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

9. DETAILS OF OTHER HEALTH INSURANCE POLICIES IN EXISTENCE

	Insured 1	Insured 2	Insured 3	Insured 4	Insured 5	Insured 6
Type of Policy						
Policy Period						
Period of Insurance						
Insurance Company						
Sum Insured (₹)						

10. MEDICAL HISTORY

Have You or any person proposed to be insured under the Policy suffered from any medical conditions or disabilities or health problems. or have been Hospitalized or have had any surgical operation be it be intermittent. recurring or otherwise. If yes. please give full details below. If space is insufficient, please continue on a separate sheet of paper. Refer to the list

Sr. No.	Symptoms/ Disorders	Insured 1	Insured 2	Insured 3	Insured 4	Insured 5	Insured 6
1	Smoke/ consume tobacco						
2	Infections						
3	HIV/AIDS						
4	Cancer/ Tumor						
5	Nutritional/ Endocrinal disorders/ Diabetes						

6	Mental psychiatric Disorders						
7	Nervous system Disorders						
8	Disorders of the Eyes/ Ears/ Nose/ throat/						
9	Disorders of tl1e circu latory system/ Heart Disease/hypertension						
10	Respi ratory Infections and Diseases, Asthma						
11	Diseases of Stomach, Intestin es, liver, appendix						
12	Bones and Joints, Spondylitis / arthritis etc.						
13	Kidney and urinary system						
14	Pregnant/Gynecological Disorders/ Prostrate						
15	Birth Defects						
16	Any other disease or surgery or accidents/burns						

Have You or any person proposed to be insured underthe Policy ever been refused insurance cover by an insurance company or been accepted on specialterms? ☐ Yes ☐ No

If yes, please give full details.

Any other relevant information of the proposed insurance which shou ld be disclosed to Us:

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

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

DECLARATION

1. I hereby declare, on my behalf and on behalf of all persons proposed to be insu red, 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 am authorised to propose on behalf of these other persons.
2. 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 insurer and that the policy will come into force only after full payment of the premium chargeable.
3. I further declare that I will notify in wri ting any change occurring in the occupation or general l1ealth of the life to be insured/proposer after tl1e proposal lias been submitted but before communication of the risk acceptance by the company.
4. I declare that I consent to the company seeking medical information from any doctor or hospital who/which at any time has attended on the person to be insu red/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 whom 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 pertaining to 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.

Additional Declarations:

1. I have been provided with the detailed terms of the policy. I have read, understood and am aware of the detailed terms of the policy.
2. I hereby give consent for receiving proposal form and policy copy in electronic form only. The provision for physical copy of the proposal form would be as per the relevant IRDA guidelines.
3. I hereby confi rm that I have insurable interest in the policy and the premium is not bo rne by any third party entity or person.
4. I/We hereby give my/our consent to the Company to verify and obtain my/our identity/address proof through Centra l KYC Registry or UIDAI or through any other modes for the purpose of undertaking KYC.
5. 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 co ntinue to be paid out of legally declared and assessed source of income.
6. 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.

7. 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 gui lty by any competent court of law under any statutes, directly or indirectly governing the prevention of money laundering.
8. 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 co urt of law under any statutes, di rectly or indirectly governing the prevention of money laundering.
9. 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

Proposer's Signature

IMPORTANT NOTES

1. The information that you give to us in th is 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. Fu rther, any policy we issue will be based on what you have communicated to us. It is therefore important that your answers are complete and accurate in all respect.
2. The questions in th is proposal are ind icative rather than 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 underwri ting by the company.
4. For a complete list of exclusions/ inclusions and other policy detai ls, kind ly refer to the policy wordings.

VERTICAL INFORMATION (FOR OFFICE USE ONLY)

Agent Details

Agent/Intermediary Name:

Agent/Intermediary Code (ID) (AO) Agent/Intermediary Contact No.

For ICICI Lombard General Insurance Company Limited

Issuing Office: Date D D M M Y Y Y Y

IRDA Reg No -1 15 Misc Code - 150

Authorized Signatory

INTERMEDIARY CONFIDENTIALITY REPORT/ INTERMEDIARY DETAILS:

I hereby declare that the customer has understood the nature of questions in the proposal form and the importance of disclosing all the material information. I declare the facts disclosed in the proposal form are true and correct to the best of my knowledge and belief. I confirm having verified the identity of the Proposer and Life Assured, source of fund and address of the customer and the proofs submitted along with this form with the original documents.

1. Nature of Work
2. How do you know the Proposer?
3. How long have you known the Proposer? (yrs)
4. Is the Proposer related to you? ☐ Yes ☐ No
   If Yes Give Details
5. Income details of Proposer (₹ Per annum)
6. Personal Asset details:
   House: ☐ Owned ☐ Rented ☐ Co. Provided Vehicle: ☐ 4Wheeler ☐ 2Wheeler ☐ NA
7. General Health details of person(s) proposed to be insured as observed/ informed to you:
   - Physical Handicap/ Deformity ☐ Yes ☐ No
   - Mental Retardation ☐ Yes ☐ No
   - History of any Illness/ Surgery ☐ Yes ☐ No

- Medical Investigations done ☐ Yes ☐ No

If answer to any of the above questions is yes, please provide details: _____

_____

8. Any other risk associated with occupation, sports pursuit or personal habits of person(s) proposed to be insured that could affect the risk in the insurance proposal, please provide details:
9. Any other material information or facts as regards to the social/ financial status and the source of funds of the proposer which might have any adverse impact on acceptance of the proposal, please provide details
10. Is the Proposer any of the following:

☐ Judge ☐ Member of Parl iament ☐ Member of state legislature National/ State level office bearer of political party

Other Remarks: Material disclosure pertai ning to any adverse habit, health or income inconsistency of the prospect

Date D D M M Y Y Y Y Place _____ _____
Signature of the Agent

Name and Code No. of the Agent _____

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: _____

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.]