Enrollment form No._____
URN No PF/4202/00

Enrollment Form - ICICI Lombard Criti Shield Plus

For official use only

Product Code: _____ Proposal No. : _____
Intermediary ID: _____ Intermediary ID: _____
Branch Name: _____ Deal No. : _____

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 Os Offices or Agents for any doubts or clarifications on the proposal form.

Terms and Conditions

- Initial waiting period (90/120/150 days) & Survival Period (0/3/7/14) days will be applicable on all covers except Section C (PA). Sum Insured can be enhanced 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.
- The liability of the Company does not commence until this Proposal has been accepted by the Company and premium realized
- The Proposer/Main applicant filling the proposal form will be solely responsible for making correct/truthful health declarations on behalf of the insured if Multilife option has been selected.

Place: _____

Date D D M M Y Y Y Y

Applicant's Signature

CUSTOMER INFORMATION - PART A

The application form is to be filled in CAPITAL LETTERS by the Proposer. Please answer all questions fully and correctly. Where any question does not apply, please mention clearly the question is not applicable.

PROPOSER// CUSTOMER INFORMATION Please fill all the particulars in CAPITAL letters only

Proposer's Name (please leave a space after each part of name) Annual Income from all sources: _ _ _ _ _ _ _ _

Mr.//Ms./Dr. _ _ _ 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 _ Third gender _

Occupation: _ Salaried _ Self Employed _ Professional _ Retired _ Housewife _ Student _ Others Details_____

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

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

_ above > 30 Lacs _____

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;

GST Number: (It Applicable) _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ PAN Card No.: _ _ _ _ _ _ _ _ _ _

Correspondence Address :

Landmark:

City: State: Pin Code:

Mobile Number*: E-mail ID:

Permanent Residence Address:

Landmark:

City: State: Pin Code:

CKYC

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

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.

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					
Name of Bank					
Account Number					
MICR					
IFSC					
Mailing Address					
Permanent Address					
Mobile Number					
Email ID					
In case of minor Nominee, kindly provide details of authorised Appointee					
Name of Appointee					
Name of Bank					
Account Number					
MICR					
IFSC					
Mailing Address					
Permanent Address					
Mobile Number					
Email ID					

FOR ICICI GROUP EMPLOYEES ONLY

Name of Organisation Employee ID

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

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 Applicant	Height (feet / inch)	Weight (kgs)	PAN No.	PEP
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					

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

DETAILS OF OTHER HEALTH INSURANCE POLICIES IN EXISTENCE

Is the insured, 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.)

Product Name	Insured Name	Policy No./ Proposal No.	Period of Insurance	Sum Insured	Claims lodged during policy period (yes/No)
1. Group secure mind					
2. Secure mind					
3. Income protect					
4. Critical illness					
5. Other health Policies					

Do you have other current or pending critical illness Insurance/ Proposal with another Company? ☐ Yes ☐ No

If Yes, specify company Name: _____

Sum Insured: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ Date of proposal D D M M Y Y Y Y

DETAILS OF THE INSURANCE PRODUCT/ PLANS - PART B

Please fill the form as per your requirement.

ICICI LOMBARD CRITI SHIELD PLUS

Tenure ☐ 1 Year ☐ 2 Years ☐ 3 Years **Plan Type** ☐ Individual ☐ Multilife

Plan Options ☐ Individual ☐ 1 A + 1 C ☐ 1A + 2C ☐ 2A ☐ 2A+1C ☐ 2A + 2C ☐ 2A + 3C

Plan Details ☐ Cancer Shield ☐ Cardiac Shield ☐ Cardiac + Cancer Shield ☐ Comprehensive Criti Shield

Sum Insured Insured 1 _____ Insured 2 _____ Insured 3 _____ Insured 4 _____ Insured 5 _____

Add-ons Cover ☐ ICU Benefit ☐ Cancer Restore* ☐ Major Surgical Procedure ☐ Personal Accident

Waiting Period: ☐ 90 days ☐ 120 days ☐ 150 days **Survival Period:** ☐ 0 days ☐ 3 days ☐ 7 days ☐ 14 days

ICU Benefit: Survival Period: ☐ 5 days ☐ 7 days

Plans & Sum Insured & other details opted above will apply for all family members.

Cost of Pre Policy Medical Check-up for policy issuance: Where ever medicals will be required, the Company will bear the cost of pre policy medical tests, however for one year policy at least 50% of the expenses shall be borne by the Insurance company in case of acceptance of proposal.

Maximum entry age for this product is 65 yrs (subject to medical UW).

*Cancer restore only applicable for Cancer Shield/ Cardiac + Cancer Shield/ Comprehensive Criti Shield.

PAYMENT DETAILS

Premium Amount ₹: _____ Cheque/DD/NEFT/RTGS Number _____

Payment Option: Cheque ☐ DD ☐ NEFT ☐ RTGS ☐ Dated: D D M M Y Y Y Y

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: _____ Name of Account Holder _____

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

AUTO - RENEWAL OPTION

Do You wish to avail an auto-renewal facility (ECS payment) by way of which we will automatically renew your Policy for the period for which it has been issued for. (Please tick Yes, if opted for) ☐ Yes ☐ No (Please fill ECS annexure if ticked yes)

Vwe 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 _____

Date D D M M Y Y Y Y

Place _____

MEDICAL AND LIFESTYLE INFORMATION

Important: You must answer the following questions truthfully. Not doing so affects your coverage in case of a Claim.

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

	Medical and Lifestyle Information	Insured 1	Insured 2	Insured 3	Insured 4	Insured 5
1	Hypertension: Duration/medication/related complications/hospitalization					
2	Diabetes Mellitus (Sugar) History : Type 1 or 2					
	a) Duration/medication/related complications/hospitalization					
3	Hyperlipidemia Cholesterol History a) Duration b) Medication					
4	Have you smoked or used any substance or product containing tobacco, or alcohol or any other substance? If yes, please state duration and average daily consumption and type					
5	Have you lost/gained weight recently How much weight have you lost or gained over the last 12 months?(Kg.) Reason for weight change _____					
6	Have you suffered from or diagnosed with any of the below: Heart and Circulatory Conditions/Disorders: chest pain, angina, congestive heart failure,coronary arter disease, heart attack, bypass surgery/ angioplasty, valve disorder/replacement, pacemaker insertion rheumatic fever, congenital heart condition, any other heart varicose veins, clots in veins or arteries, blood disorders, anti-coagulant therapy etc.					
7	Urinary Conditions/Disorders: Blood in urine, kidney failure, dialysis or Any Other Kidney/Urinary Tract Or Prostate Disease.					
8	**Musculoskeletal Conditions/Disorders:** Spinal disorders/Surgeries Osteomyelitis Joint Replacement Or Any Other Disorder of Muscle/ Bone/ Joint/ ligaments, tendons or discs, gout, herniated disc, fractures/ accidents/ implants, amputation/prosthesis, Muscle weakness, Polio etc.					

9 **Respiratory Conditions/Disorders:** Tuberculosis, Asthma, Bronchitis, Chronic Obstructive Pulmonary Disease COPD, ILD/ARDS/Lung failure, coughing of blood, or any Other Lung Respiratory Disease.					
10 **Digestive Conditions/Disorders:** hepatitis NB/C/other, Ulcerative colitis, Chron's disease, Inflammatory/ irritable bowel disease, Cirrhosis, any Other Gastro Intestinal condition.					
11 Cancer/Tumor: Benign Or Malignant tumor, Any Growth/Cyst, any Cancer diagnosed earlier and/or treatment taken for cancer.					
12 Brain/ Nervous System/ Mental/ Psychiatric Conditions/ Developmental Disorders/Congenital/Birth defect: paralysis, head injury, stroke, multiple sclerosis, seizures/epilepsy or any Other Brain/ Nervous System Disease, Mental/Psychiatricdisorder, autism, Transient ischemic attack ,any major brain surgery etc.					
13 Eye, Ear, Nose and Throat Disorders: Loss of Eye, Loss of speech, Hearing loss, Any other disorder of Eye, Ear, Nose and Throat.					
14 Sexually Transmitted Diseases: HIV/AIDS, immunodeficiency or any venereal disease (VD)/sexually transmitted disease(STD).					
15 Metabolic, Endocrine Conditions/Disorders and autoimmune/genetic disorder: thyroid disorder, lupus, scleroderma, thyroid disorders, Thallasemia, anemia, Hemophillia, etc.					
16 Is any female member pregnant, tested positive with a home pregnancy test, or ectopic pregnancy, infertility treatment					
17 Does the person proposed to be insured suffer from any chronic or long-term medical condition, or have any other disability, abnormality or recurrent illness or injury or unable to perform normal activities?					
18 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).					
19 Does the individual have a family history of any disease like Heart disease or brain disease or cancer or organ failure or autoimmune or genetic disorder.					

*The above list of questions is subject to modification as per the requirement.

SECTION B

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. Premium will be forfeited.

*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.

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- PART H

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/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 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.

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.

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

DECLARATION WHEN THE PROPOSAL 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 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: _____

_____

_____

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

DETAILS OF ALL PREVIOUS HEALTH INSURANCE POLICIES SINCE INCEPTION

Name of Insurer _____

Policy Period _____ Name of the product _____

INTERMEDIARY DECLARATION AND DETAILS/PRINCIPAL OFFICER DETAILS

I, _____<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:

Name: _____

Code: _____ Contact No.: _____

Email ID of the branch: _____

Branch/Office: _____