ICICI Lombard
Nibhaye Vaade

INTERNATIONAL TRAVEL INSURANCE PROPOSAL FORM

For Office use only **URN No.- PF/4129/00**

Intermediary/Specified Person Name	
Intermediary/Specified Person Code	
Intermediary/Specified Person Contact No	
Intermediary/Specified Person Email ID 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. If you think any fact is material, please disclose it.
- Insurance benefit shall become voidable at the option of the Company, in the event of misrepresentation, or established fraud or non-disclosure by the Insured or anyone acting on his behalf to obtain any benefit under this Policy.
- 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 realised.

Proposer's/ Insured's Signature

PROPOSER DETAILS

Proposer's name: (First) (Middle) (Last)

Mr. / Ms.:

Correspondence Address

City: State: Country:

Pin code: Home Phone Number: Fax Number:

Date of Birth: D D M M Y Y Y Y ABHA No. Sex: Male Female Third Gender

OCCUPATION DETAILS: Salaried Self Employed / Business Other (Please specify)

Income per annum:

Email ID: Mobile Number:

CKYC no.

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

Are you or any of the proposed applicants/beneficial owner a PEP* or a Family member/ Close relatives/Associates of PEPs? Yes No

If yes, explain nature of relationship and position held by PEP:

*Politically Exposed Persons (PEPs) are individuals who are or have been entrusted with prominent public functions in a foreign country, e.g., Heads of States/Governments, senior politicians, senior government/judicial/military officers, senior executives of state-owned corporations, important political party officials, etc.

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

DETAILS OF PERSONS TO BE INSURED

(Please mention details of all the persons proposed to be insured under the policy)

		Insured 1	Insured 2	Insured 3	Insured 4	Insured 5	Insured 6
Name as per Passport							
Date of Birth							
Relationship with Proposer							
Passport Number							
ABHA Number							
Visa Type	Immigrant	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No
	Non - Immigrant	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No
Is the Insured currently in india		Yes No	Yes No	Yes No	Yes No	Yes No	Yes No

I agree to share my medical records with ICICI Lombard / TPA through ABH Yes No

For generating ABHA no please visit website (ndhm.gov.in) Post generation of the ABHA no please share the same with us.

Resident of India	
Family Doctor's Name, Address and Contact Details	

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)

	1st Appointee	2nd Appointee	3rd Appointee	4th Appointee
Name of Appointee				
Date of Birth of Appointee	DD/MM/YYYY	DD/MM/YYYY	DD/MM/YYYY	DD/MM/YYYY
Percentage of Nomination	_____%	_____%	_____%	_____%
Relation of the Appointee with the Insured				
Mobile No.				
Eamil ID				
Present Address				
Permanent Address				

*Please write the assignee name also in case the nominee is a minor #Please provide the details of the guardian in case the nominee is a minor

	Pre-Existing Disease - Please declare if any of the insured traveling is suffering from/has ever suffered from or had symptoms for, taken medications/has undergone any hospitalisation/ surgery for the below mentioned diseases	Yes	No
a.	**Heart Disease** - Heart and Circulatory Conditions/ Disorders: Chest pain, angina, heart failure, coronary artery disease/blockage, heart attack, cardiac bypass surgery/ angioplasty, valve disorder/ replacement surgery, pacemaker insertion, congenital (by birth) heart condition, abnormal heart rhythm or any type of heart disease		
b.	**Liver Disease:** Chronic liver failure or disease, liver cirrhosis, liver transplant, autoimmune liver disease, biliary cirrhosis, fulminant/ recurrent hepatitis, shrunken liver, fibrotic liver and acute & chronic pancreatitis		
c.	**Kidney Disease:** Chronic kidney failure or disease, kidney transplant, dialysis, nephropathy, kidney cyst, polycystic kidney disease, nephritic syndrome, solitary kidney, renal mass, hydronephrosis, shrunken kidney and nephritic syndrome		
d.	**Cancer:** Any type of Cancer or tumor of any kind.		

Please Note: Any claim due to or arising out of pre-existing medical condition/ailment whether declared or undeclared is not covered under the policy

PAST INSURANCE DETAILS

Sr. No.	Policy Period	Insurance Company	Product name	Date of issuance of First Policy	Premiums Paid	Claims
1.						
2.						
3.						

Dated __ __ __ __ __ __ __ __ Place: _____

Proposer's/ Insured's Signature

TRAVEL DETAILS

Purpose of visit: Business ☐ Leisure ☐ Visiting Family or Friends ☐ Others _____

Mode of travel (Please mention mode of travel): Air ☐ Sea ☐ Road ☐

Details of Trip: From D D / M M / Y Y Y Y To D D / M M / Y Y Y Y Days: __ __

Are you going to participate in Training or Competitions of professional or semi professional sports nature or other such activity? ☐ Yes ☐ No

If YES, details: _____

PERIOD OF INSURANCE

For Single Trip	For Multi-Trip (one year policy)
Journey Start Date D D / M M / Y Y Y Y Journey End Date D D / M M / Y Y Y Y Total number of days: __	Date of Commencement of Insurance D D / M M / Y Y Y Y Multi Trip (days) - 30 ☐ 45 ☐ 60 ☐

COVERAGE DETAILS

Geographical scope	Plan requested		Sum Insured options (in USD)
Worldwide	Single Trip	Gold ☐ Platinum ☐ Silver ☐ Senior citizen ☐	5,00,000 ☐ 2,50,000 ☐ 1,00,000 ☐ 50,000 ☐ 25,000 ☐
	Multi Trip	Gold ☐	5,00,000 ☐ 2,50,000 ☐ 1,00,000 ☐
Schengen Countries		Gold-S ☐ Platinum-S ☐ Senior citizen-S ☐	1,00,000 ☐ 50,000 ☐
Other Countries		Gold ☐ Platinum ☐ Silver ☐ Sr. citizen ☐ Asia ☐	5,00,000 ☐ 2,50,000 ☐ 1,00,000 ☐ 50,000 ☐ 25,000 ☐

DETAILS OF PROPERTY TO BE COVERED (VALID ONLY FOR PLATINUM PLAN)

Address (If different from Correspondence Address): _____

City: _____

State: _____ Country: _____ Pin code: _____

Bank Account Details

	Bank Details of insured	Bank Details of Nominee	Bank Details of Appointee
Beneficiary Name			
Bank Name			
Bank Account Number			
IFSC CODE			
MICR NUMBER			
BRANCH			

PAYMENT DETAILS

Cash ☐ Cheque ☐ DD ☐ Credit/ Debit Card ☐ Premium Amount ` ☐☐☐☐☐☐☐

Cheque/ DD No. ☐☐☐☐☐☐☐☐☐☐ Cheque/ DD Date ☐☐/☐☐/☐☐☐☐ Branch (if cheque)_____

Account holder name : ☐☐

Bank name : ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ Account No. : ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

IFSC Code : ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

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

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 a-•ects 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 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.
- I agree that the Policy shall become voidable at the option of the company, in the event of misrepresentation, or established fraud or non-disclosure by the Insured or anyone acting on his behalf to obtain any benefit under this Policy.
- I have read and understood the policy terms & conditions and agree to abide by them.
- I/ we hereby agree that the insurance coverage under the policy will commence only on realization of full premium. Receipt of proposal form by the company shall not be construed as acceptance of proposal.
- I/We hereby give my/our consent to the Company to verify and obtain my/our identity/address proof 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.

Proposer's Name: (First) ☐☐☐☐☐☐☐☐☐☐☐☐ (Middle) ☐☐☐☐☐☐☐☐☐☐☐☐ (Last) ☐☐☐☐☐☐☐☐☐☐☐☐

Dated: ☐☐/☐☐/☐☐☐☐ Place: ☐☐☐☐☐☐☐☐☐☐☐☐ Proposer's 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

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: ☐☐/☐☐/☐☐☐☐ Place: _____

Relationship with Proposer: ☐☐

Address of Witness: ☐☐

☐☐

☐☐

INTERMEDIARY DECLARATION AND DETAIL/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) Ware 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:

STATUTORY WARNING

PROHIBITION OF REBATES (Under Section 41 of Insurance Act 1938)

- 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.
- Any person making default in complying with the provisions of this section shall be punishable with fine, which may extend to Rs. Ten Lakhs.

ICICI Lombard
GENERAL INSURANCE
WE KEEP YOU GOING

Mailing Address: ICICI Lombard General Insurance Company Limited, Interface Building No.11, 401/402 4th Floor, New Link Road Malad (W), Mumbai - 400 064.
Corporate Address : ICICI Lombard General Insurance Company Limited,
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 • Alternate No.: +91 92236 22666 (Chargeable)
ICICI Lombard General Insurance Company Limited. Insurance is the subject matter of the solicitation.
IRDA Reg. No. 115. **UIN** ICITIOP02002V020102, **CIN** L67200MH2000PLC129408, **Misc** 129
For more details on claims please visit : www.falck.com