ICICI LOMBARD GENERAL INSURANCE COMPANY LIMITED

Regd. Office: ICICI Bank Towers, Bandra Kurla Complex, Mumbai – 400 051

Tel: (+91 22) 2653 1414 Fax: (+91 22) 2653 1657

Corporate Office: ICICI Lombard House, 414, Veer Savarkar Marg, Near Siddhi Vinayak Temple, Prabhadevi, Mumbai-400025. Tel: (+91 22) 2492 4100 Fax: (+91 22) 2492 3503

For Office use Only

URN No.- PF/4029/00

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)
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 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	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.
4	Kindly contact the Company's Offices or Agents for any doubts or clarifications on the proposal form.
	The company holding insurance is registered in India and all the employees insured in the policy should be residents of India and are permanent employees of the company.
5	I/We understand that the product "Overseas Group Travel Insurance" offers overseas mediclaim cover for Employer-Employee groups and their dependent.

NOTE: The liability of the Company does not commence until this Proposal has been accepted by the Company and premium realised. Overseas Group Travel Insurance offers overseas mediclaim cover for Employer-Employee groups and their dependents.

_____

Proposer's Signature

1. Details of Proposer/ Policy Holder:

Proposer's name: M/s. _____ Date: _____

Correspondence Address: _____

_____

_____

City: _____ Pin Code: _____ State: _____ Country: _____

Phone Number: _____ Mobile Number: _____ Fax Number: _____

E-mail ID: _____

Occupation _____ Income per annum _____ CKYC no. _____

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

I agree to share my medical records with ICICI Lombard / TPA through ABHA: Yes ☐ No ☐
For generating ABHA no please visit website (ndhm.gov.in) Post generation of the ABHA no please share the same with us.

Do you wish to avail a physical copy of your policy documents? Yes ☐ 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.

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				

2 . Travel Details:

a. Purpose of visit: Business

b. Geographical Scope of Cover:

c. Type of Trip: Single-trip / Multi-trip:

d. Max Trip duration:

e. Details of Trip:

From:	To:	Days:
From:	To:	Days:
From:	To:	Days:
From:	To:	Days:
From:	To:	Days:

f. Mode of travel (Please mention mode of travel from place of residence and mode of travel while on trip and class of travel): _____

g. Common Carrier opted for Trip:_____

h. Activities to be undertaken while on trip? _____

i. Please provide the details of past insurance:

Sr. No	Policy Period	Insurance Company	Product name	Date of issuance of First Policy	Premiums Paid	Claims
1.						
2.						
3.						
4.						
5.						
6.						

3. Coverage Details:

a. Type of Trip: Single / Multi-trip/ Single Flight

b. Coverage Required: Please Put a tick against the covers opted (Mandatory to choose atleast two Benefits).Also mention the voluntary deductibles against the benefits, to get reduction in premium, wherever applicable.

Sno.	Covers	Put a Tick	Sum Insured	Deductible
1	Medical Expenses(Includes Medical Evacuation Benefit)			
2	Dental Expenses			
3	Repatriation of Remains(Included in the overall medical benefit SI)			
4	Personal Accident (Includes AD & D Common carrier)			
5	Personal Liability			
6	Checked-In Baggage Loss			
7	Checked-In Baggage Delay			
8	Passport Loss			
9	Trip Cancellation and Interruption(Trip curtailment included)			
10	Replacement and Rearrangement of staff			
11	Financial Emergency Assistance			

* Voluntary Deductibles chosen by Insured Person(s)

Details of Add- On Covers

Please put a tick, if opting for Add-On Covers

Sr. No.	Benefits	Put a Tick	Sum Insured	Compulsory Deductible
1	Professional or Semi-Professional Sporting Activity			

If involved in sporting activities: Training or Participation in competitions of professional or semi-professional nature: YES / NO.

If YES, details: _____

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			

4. Period of Insurance for Master Policy:

Date of Commencement of Insurance:	Date of Expiry of Insurance:	No. Of Mandays:

5. Payment Details: (Please tick the appropriate option and fill the amount details)

Cash	Cheque	Credit Card	Premium Amount Rs.

Cheque No. / Credit Card No.	
Cheque Date	
Branch (if cheque)	
Account Holder Name:	
Account No.:	
IFSC Code:	
Bank Name / Credit Card Name	
If Credit Card (please tick whether): Master / Visa / Amex / Diners/ Others Credit Card	
CVV Number:	

6. Any additional information relevant to the policy applied for:

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

Declaration

I. "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.

ii. 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.

iii. 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.

iv. I/We declare and consent to the company seeking medical information from any doctor or from 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 beassured/ 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.

v. 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."

vi. I/We understand that the product "Overseas Group Travel Insurance" offers overseas mediclaim cover for Employer-Employee groups and their dependent.

vii. 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.

viii. 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.

ix. I/We understand that the Company has right to call for documents to establish source of funds.

x. I/We hereby declare that the details furnished above are true and correct to the best of my/ourknowledge and belief and I/we undertake to inform you of any changes therein, immediately, not later than 30 days.

xi. 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.

xii. 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.

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.

Date	D	D	M	M	Y	Y	Y	Y

Signature of the Proposer/ Policy Holder

(Designation)

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: _____

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: _____

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.

2. 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** ICITIOP22078V042122, **CIN** L67200MH2000PLC129408, **Misc** 029
For more details on claims please visit : www.falck.com