Enrolment form No._____

PROPOSAL FORM - PERSONAL PROTECT POLICY

FOR OFFICIAL USE ONLY

URN No.: PF/4111/01

Group I.D.No: ☐☐☐ Customer I.D.No: ☐☐☐☐☐☐ Business Sector ☐ Urban ☐ Rural ☐ Social

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.

Note: Our liability does not commence until the premium is duly received and proposal has been accepted by Us.

SCOPE OF COVER

Section - A

The Company agrees to pay to the Insured Person (or his nominee/ legal heir, as the case may be) a sum as compensation on occurrence of any Insured Event, under different Benefit(s) (Death / PTD / PPD/ TTD) and extensions arising due to an Injury sustained during the Policy Year /Policy Period but not exceeding the Sum Insured as specified under the respective Benefits and extensions.

Section - B

The Company agrees to pay to the Insured Person a sum as compensation on occurrence of any Insured Event, under different Benefit(s) arising due to an Injury sustained during the Policy Year / Policy Period but not exceeding the Sum Insured as specified under the respective Benefits.

NOTE:

Benefits of the Personal Protect Policy are available for members of a Family named in the policy schedule, aged between - years

Family Member - means an Insured Person's legal spouse, children, parents and legally adopted children. ☐☐☐☐

SIGNIFICANT EXCLUSIONS

This Policy does not cover losses arising out of Suicide / Attempted Suicide, Self-Injury, Venereal Diseases, War and Nuclear Perils and Pregnancy. For a detailed set of exclusions, kindly refer the policy document.

NOTE

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

CUSTOMER INFORMATION - PART A

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

Name of the Proposer: (please leave a space after each part of name) ☐☐☐☐☐☐

Mailing Address of Proposer: (please leave a space after each part of address)

Landmark:

City/Town: State: Pin Code:

Mobile Number*: E-mail ID:

Proposer's Occupation

Occupation: Salaried Self Employed Professional Others Details

Occupation and Nature of Business/Work: Income per annum

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.

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:

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

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

TABLE OF BENEFITS - PART B

Section	Benefit	Cover Name Coverage	Benefit Amount	Sum Insured (₹)
SECTION A	Benefit 1	Death resulting from Accident	100% of Sum Insured	
	Benefit 2	Permanent Total Disablement resulting from Accident	100% of the Sum Insured	
	Benefit 3	Permanent Partial Disablement resulting from Accident	As per disability % indicated	
	Benefit 4	Temporary Total Disablement resulting from Accident	X% of Sum Insured or ₹ _____/ week subject to max weeks	
EXTENSIONS UNDER Section A				Sum Insured (₹)
EXTENSIONS UNDER Section A	Extension 1	Carriage of Dead Body	X% of the Benefit Amount payable under Benefit 1 of under Section A or the Sum Insured under Section A Carriage of Dead Body benefit	
	Extension 2	Medical Benefits Extension	X % of Benefit Amount payable under Benefit 1/2/3/4 of Section A or ₹ _____ per event. Payment of all claims of Ext 2 of Sec A in aggregate for Policy Period in no case shall exceed the Sum Insured under Medical Benefits Extension	
	Extension 3	Hospital Daily Allowance Extension	` X/ Hospital Confinement day under Benefit 1/2/3/4 of Section A. Payment of all claims of Ext 3 Sec A in aggregate for Policy Period in no case shall exceed the Sum Insured under Hospital Daily Allowance Extension	
	Extension 4	PTD Improvement Benefit Extension	X times claim payable under Benefit 2 of Section A. Payment of all claims under Ext 4 of Sec A in aggregate for Policy Period in no case shall exceed the Sum Insured under PTD Improved Benefit Extension.	
	Extension 5	PPD Improvement Benefit Extension	X times claim payable under Benefit 3 of Section A. Payment of all claims under Ext 5 of Sec A in aggregate for Policy Period in no case shall exceed the Sum Insured under PPD Improved Benefit Extension.	
	Extension 6	Children's Education Grant Extension	X% of Claim payable under Benefit 1/2 of Section A per child per event subject to a maximum of events. Payment of all claims under Extension 6 of Sec A in aggregate for Policy Period in no case shall exceed the Sum Insured under Children Education Grant Extension.	
	Extension 7	Ambulance Charges Extension	Upto ₹ _____ per event subject to a maximum of events. Payment of all claims under Ext 7 of Sec A in aggregate for Policy Period in no case shall exceed the Sum Insured of Ambulance Charges	

			Extension. Applicable to Benefit 1/2/3/4 of Section A	
	Extension 8	Funeral Expenses Extension	X% of the Sum Insured under Benefit 1 of Section A or ₹___ . Applicable to Benefit 1 of Section A	
	Extension 9	Repatriation of Remains Extension	X% of the Sum Insured under Benefit 1 of Section A or the ₹ _____ . Applicable to Benefit 1 of Section A	
SECTION B	Benefit 5	Accidental Hospital Confinement	` X/ day subject to a maximum of Y days provided minimum hospitalization for Z consecutive days. Payment of all claims under Benefit 5 of Section B in aggregate for a Policy Period/Policy Year in no case shall exceed the Sum Insured mentioned against Accidental Hospital Confinement Allowance Benefit	
	Benefit 6	Accidental Hospitalization Expenses Reimbursement	Upto ₹ per event subject to a maximum events provided minimum hospitalization is for consecutive days. Payment of all claims under Benefit 6 Sec B in aggregate for a Policy Period/Policy Year in no case shall exceed the Sum Insured against Accidental Hospitalization Expenses Reimbursement Benefit	
	Benefit 7	Convalescence Benefit	₹ per event subject to a maximum events provided minimum hospitalization for Y consecutive days. Payment of all claims under Benefit 7 of Sec B in aggregate for Policy Period/Policy Year in no case shall exceed the Sum Insured against Convalescence Benefit	
	Benefit 8	Double Benefit	₹ per event subject to a maximum events provided minimum hospitalization for Y consecutive days. Payment of all claims under Benefit 8 of Sec B in aggregate for Policy Period/Policy Year in no case shall exceed the Sum Insured against Double Benefit Amount	

RISK DETAILS - PART C

Period of Insurance: Policy Start Date D D M M Y Y Y Y Policy End Date D D M M Y Y Y Y

Number of persons to be insured: ☐☐☐☐☐ **Total Capital Sum Insured: ₹** ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Details of persons insured ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

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

Name	DOB Age	Gender	Relationship with the Policyholder	Nominee	Relationship of the Insured with the Nominee	Occup-ation	Risk Category	Benefits / Extensions Opted	Periodical Benefit (₹)	Payout Period (in _____)	Premium	ABHA No.

Risk Category:

Category I - Doctors, Lawyers, and persons engaged in clerical and Administrative staff.
Category II - Builder, Contractor, Engineer on site, workers, Mechanics, Driver & Manual labourers.
Category III - Persons working in mines, explosive units, Electrical installations on line, Racing, Circus, Skiing, Mountaineering, Ballooning, Winter Sports & Polo.

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

BENEFITS & EXTENSIONS

Section - A - Benefits

Sr. No.	Benefits	Yes / No	Details
Benefit 1	Death resulting from Accident	☐ Yes ☐ No	
Benefit 2	Permanent Total Disablement resulting from Accident	☐ Yes ☐ No	
Benefit 3	Permanent Partial Disablement resulting from Accident	☐ Yes ☐ No	
Benefit 4	Temporary Total Disablement resulting from Accident	☐ Yes ☐ No	

Extensions under section A

If you want to avail any of the following extensions under section A of the Policy by the payment of additional premium, please specify:

Sr. No.	Extensions	Yes / No	Details
Extension 1	Carriage of Dead Body	☐ Yes ☐ No	
Extension 2	Medical Benefits Extension	☐ Yes ☐ No	
Extension 3	Hospital Daily Allowance Extension	☐ Yes ☐ No	
Extension 4	PTD Improvement Benefit Extension	☐ Yes ☐ No	
Extension 5	PPD Improvement Benefit Extension	☐ Yes ☐ No	
Extension 6	Children's Education Grant Extension	☐ Yes ☐ No	
Extension 7	Ambulance Charges Extension	☐ Yes ☐ No	
Extension 8	Funeral Expenses Extension	☐ Yes ☐ No	
Extension 9	Repatriation of Remains Extension	☐ Yes ☐ No	

Section - B - Benefits

If you want to avail any of the following extensions under section A of the Policy by the payment of additional premium, please specify:

Sr. No.	Benefits	Yes / No	Details
Benefit 5	Accidental Hospital Confinement Allowance Benefit	☐ Yes ☐ No	
Benefit 6	Accidental Hospitalization Expenses Reimbursement	☐ Yes ☐ No	
Benefit 7	Convalescence Benefit	☐ Yes ☐ No	
Benefit 8	Double Benefit	☐ Yes ☐ No	

DETAILS OF OTHER HEALTH INSURANCE POLICIES IN EXISTENCE

Is any proposer or the person proposed, 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.)

Insured Name	Policy No. / Proposal No.	Period of Insurance	Sum Insured	Claims lodged during policy period (Yes/No)

DETAILS OF ALL PREVIOUS HEALTH INSURANCE POLICIES SINCE INCEPTION

Name of Insurer ☐☐☐

DECLARATION

1. 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.
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 insurance company and that the policy will come into force only after full receipt of the premium chargeable.
3. 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.
4. 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.
5. 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.
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 guilty by any competent court of law under any statutes, directly or indirectly governing the prevention of money laundering.
8. I/We hereby give my/our consent to the Company to verify and obtain my/our identity/address proof for the purpose of undertaking KYC.
9. 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.
10. 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

Designation

Proposer's Signature

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.]

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: