Proposal form: Financial Shield Package Policy – Group

For official use only

MO EMP ID _____

GUIDELINES FOR COMPLETION OF THE FORM (To be filled by the /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 Policyholder 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 non-disclosure 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.

Customer 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

Name of the Group Policy Holder (organization/institute/association): □□□□□□□□□□□□□□□□□□□□□□
(Please leave a space after each part of name)

Address of Group Policy Holder: □□□□□□□□□□□□□□□□□□□□□□□□□□
(Please leave a space after each line of address) □□□□□□□□□□□□□□□□□□□□□□□□□□
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Nature of Group: Employer-Employee □ Non-employer-Non-employee □

If non-employer-employee: Please state nature of group: _____

Contact No.: ||||||||||| Email ID: □□□□□□□□□□□□□□□□□□□□

Type of business: □□□□□□□□□□□□□□□□□□□□ PAN No.: ||||||||||

GSTIN No.: □□□□□□□□□□□□

Aadhar No. : □□□□□□□□□□

CKYC No : □□□□□□□□□□□□□□□□□□□□

☐ **Politically Exposed Person (PEP) ☐ Related to a Politically Exposed Person No

Any other information:_____

"Politically Exposed Persons (PEPs)" are individuals who are or 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.

Status (please tick any one):

☐ Private Limited Co. ☐ Public Ltd. Co. ☐ Unincorporated Association or Body of Individuals

☐ Partnership/LLP ☐ Trust/ Foundation ☐ Government

☐ NGO/NPO (If yes, obtain DARPAN Portal Registration number.....)

☐ Others (please specify) _____

Agent Details

Agent/ Intermediaries Name: □□□□□□□□□□□□□□

Agent/ Intermediaries Code: □□□□□□□

Agent/ Intermediaries Contact No. : □□□□□□□□□□

Risk details

Policy Period (DD/MM/YYYY): □□ /□□ /□□□□ to □□ /□□ /□□□□

Policy tenure: _____

Expected number of persons to be insured in the group: □□□□□□□□□□□

Table of benefits:

	Category	Sub sections	Conditions, if any	Cover type	Type	Waiting Period	Insured Details
Section A	Loss of job	Involuntary unemployment		Benefit	Base		Name of the Insured
Section B	Cyber frauds	Unauthorized transactions: Bank account, credit/debit cards, e wallets	Min Loss amount: 10k/25k/50k/100k	Benefit	Optional		Name of the Insured
Section C	Home protect	Home building and Household assets	Min. Loss amount: 50k/100k/150k	Benefit	Optional		Name of the House owner
Section D	Business shutdown	Loss of business in case of shutdown	Min no of days of business shutdown: 3/5/7/10/15/30 days	Benefit	Base		Name of the business entity
Section E	Family emergency	Accidental death	Self/Immediate family members (Spouse/Children/Parents/Parents-in-law)	Benefit	Optional		Name of the Insured
		Permanent disablement	Self/Immediate family members (Spouse/Children/Parents/Parents-in-law)				
		Illness/Injury resulting in hospitalization	Self/Immediate family members (Spouse/Children/Parents/Parents-in-law)				
			Min no of days of hospitalization: 1/2/3/5/7/10 days				
Section F	Trip cancellation	Travel booking cancellation cover		Indemnity	Optional		Name of the Insured
Section G	Event cancellation	Event cancellation cover	Named family members covered would be	Indemnity	Optional		Name of the Insured
Section H	Broken Bones Benefits	Accidental Injury that solely, directly and immediately results in a fracture		Benefit	Optional		Name of the Insured

Sum Insured:

Industry: ……

Premium details:

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(Applicable for non-contributory policy)

Premium Amount: Rs. _____

DD /Cheque Amount: Rs. _____

DD/Cheque No. / In case of NEFT please specify NEFT details: _____

Issuing Bank Name: _____

DD/Cheque Date: __/__/____

Policy tenure: Annual □ Half-Yearly □ Quarterly □ Monthly □

Declarations

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1. I 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 am 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 insurer and that the policy will come into force only after full payment of the premium chargeable.
3. I further declare that any change occurring in the occupation or general health of the life to be insured/policyholder after the proposal has been submitted but before communication of the risk acceptance by the company will be notified in writing by the insured person.
4. I declare that I consent to the company on behalf of all persons proposed to be insured, seeking medical information from any doctor or hospital who/which at any time has attended on the person to be insured/policyholder or any health or any other information from any past or present employer concerning anything which affects the person to be insured/policyholder and seeking information from any insurer to whom an application for insurance on the person to be insured /policyholder 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/policyholder for the sole purpose of underwriting the proposal and/or claims settlement and with any Governmental and/or Regulatory authority.
6. I have been provided with the detail terms of the policy. I have read, understood and aware of the details terms of the policy.
7. I declare that the contents of this proposal form and other documents have been fully explained to me and I have fully understood the significance of the proposed contract.
8. 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.

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
11. 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, not later than 30 days.
12. 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: □□□□□□□□ Place: □□□□□□□□□□□□□□□□□□□□

Policyholder Signature: _____

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:

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)

(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.

Mailing Address ICICI Lombard General Insurance Company Limited,
ICICI Lombard House 414, Veer Savarkar Marg, Siddhi Vinayak Temple, Prabhadevi, Mumbai 400025 Visit Us at: www.icicilombard.com • E-Mail Us at: customersupport@icicilombard.com • Toll Free Number: 1800 2666. • CIN No. L67200MH2000PLC129408• IRDA Registration No. 115