Enrollment form No._____
URN N0-PF/4065/03

Enrollment Form - SECURE MIND

TO BE FILLED BY THE PROPOSER

Please ensure that the details furnished in the proposal form are correct and complete. The company's decision for acceptance of the risk will be on the basis of information provided below. In case of any doubt regarding the information to be provided, please seek advice from your insurance advisor or agent. Please attach additional sheets if required.

IL Location _____ M.O. Name _____ Proposal No.: _____

GUIDELINES FOR COMPLETION OF THE FORM

1. Please answer all 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. The Policy shall become voidable at the option of the Insurer, in the event of any untrue or incorrect statement, misrepresentation, non-description or on 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.
4. 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 the full premium received.

SCOPE OF COVER

This insurance Policy would pay an amount as specified in the policy in the event of the following

Cover	Sum Insured
a) Major Medical illness(es) as specified in the policy	
b) Death or Permanent Total Disablement of Insured on account of an Accident	
c) Loss of Job (3 EMI)	

*Benefit - C: Loss of Job is only available for Salaried employees.

Loss of Income on account of loss of employment(Termination/Retrenchment/Layoff/Permanent Dismissal): is available only for salaried individuals, where Loss of Employment occurs on account of insured person suffering an Illness or Injury due to an Accident.

Unemployment from any occupation or job which is Casual, Temporary, Seasonal or contractual in nature, or where the Insured Person is not on the direct payroll of the employer is excluded (Termination/ Retrenchment/Layoff/ Permanent Dismissal on account of any other reason other than Insured persons health or accident is excluded.

CUSTOMER INFORMATION - PART A

PROPOSER DETAILS

(please leave a space after each part of name)

First Name Middle Name Last Name

Date of Birth: D D M M Y Y Y Y PAN Card No.:

Proposer mailing address

Landmark:

City: State: Pin code:

Gender: Male ☐ Female ☐ ABHA No

CKYC:

Are you or any of the proposed applicants 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;"

Marital Status: ☐ Married ☐ Unmarried Occupation:

Mobile Number : E-mail

Name of Family Doctor

Mobile Number : E-mail

GST Number: (It Applicable)

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/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					

DETAILS OF PERSONS TO BE INSURED

Name of the Insured	Gender (M/F)	Date of Birth (DD/MM/YY)	Relationship with Applicant	Name of the Medical Illness or Procedures (refer list below)*	Name of Nominee (only 1 allowed)	Relationship with Nominee
		D D M M Y Y Y Y				

Policy Start Date: D D M M Y Y Y Y Policy End Date: D D M M Y Y Y Y Sum Insured: _ _ _ _ _

Subject to maximum of 3 years policy tenure.

* Nominee details are mandatory.

*Please mention the appropriate Major medical illness or procedure in the appropriate cell above in case the individual to be insured (i) has either been diagnosed of or is suffering from any symptoms pertaining to; or (ii) has undergone any of the below-mentioned major medical illness or procedures :

1. Myocardial Infarction 2. Stroke 3. Coronary Artery Bypass Surgery 4. End Stage Renal Failure 5. Cancer 6. Multiple Sclerosis 7. Heart Valve Replacement 8. Paralysis 9. Major Organ Transplant 10. Benign Brain Tumor 11 . Parkinson's Disease 12. Alzheimer's Disease 13. End Stage Liver Disease 14. Surgery of Aorta 15. Coma 16. Major Burns 17. Deafness 18. Loss of Speech

HEALTH STATUS

PLEASE ANSWER ALL QUESTIONS BY CHECKING EITHER THE YES OR NO BOX

Medical and Lifestyle Information	Insured 1
1. Are you now in good health and entirely free from any mental or physical impairments or deformities?	
2. Height _____ (Cm.) Weight _____ (Kg.) How much weight have you lost or gained over the last 12 months? _____ (Kg.) Reason for weight change: _____	
3. Have you ever suffered or do you now suffer from:	
a) Diseases of the circulatory system (eg. Heart trouble, chest pain, rheumatic fever, high blood pressure, diseases of the arteries and veins)?	
b) Diseases of the respiratory system (eg. Tuberculosis, asthma, persistent cough, pneumonia or emphysema)?	
c) Diseases of the genito-urinary system (eg. Infections of the kidneys, urinary or genital organs, renal stones, venereal disease)?	
d) Diseases of the gastrointestinal system (eg. Digestive disorders, gastric or duodenal ulcer, hepatitis B, hepatitis C or other disorders of the liver, disorders of the gall bladder)?	
e) Diseases of the nervous system or mental disorders (eg. Stroke, epilepsy, fits or fainting attacks, frequent headaches, nervous breakdown, depression or other mental or psychiatric disorder)?	
f) Diabetes mellitus, cancer or tumour of any kind, or any diseases of the blood, glands, spleen, ears, eyes or skin?	
g) Unexplained night-sweats and/or loss of weight, persistent fever, chronic or recurrent diarrhea, unexplained infections or swollen glands?	
h) Any history of Major Accident or Spinal Disease/Injury?	
i) Any other diseases or ailments not mentioned above?_____	
4. Have you ever taken narcotics or other habit forming drugs or been treated or advised in connection with your alcohol consumption or the taking of drugs?	
5. Have you or any of your immediate family members (father, mother, brother or sister) have/ had cancer, heart attack, or stroke?	
6. Have you ever received or do you now receive any personal accident, disability benefit, critical illness or disability/medical - related payments?	
7. Have you ever had or been advised to have a blood test or have you ever been refused as a blood donor?	
8. Do you participate or do you intend to participate in any hazardous sports or activities such as motor sports, climbing, parachuting, hang-gliding or aviation except as a Fare- paying passenger?	
9. Are you pregnant (or female only)/ If yes, please state how many months. Please state if you had any pregnancy related complication during your previous pregnancy/ delivery?	

PERSONAL INFORMATION COLLECTION STATEMENT

The information you provide to us is collected to enable us to carry on insurance business and may be used for the purpose of (i) any insurance or financial related product or service or any alterations, variations, cancellation or renewal of them: (ii) any claim or analysis of it; and may be transferred to any related company or any other company carrying on insurance or reinsurance related business or any intermediary or claims investigator or other service provider providing services relevant to insurance business or any association or federation of insurance companies that exists or is formed from time to time.

You have right to obtain access to and to request correction of any personal information concerning yourself held by ICICI Lombard. Requests for such access can be made to the Company.

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 hereby confirm that I am aware that enrolment to this product is purely voluntary and is not linked to me availing of any other facility from the bank.
7. I hereby confirm that the premium towards my insurance cover will not be borne by any third party entity I person(s), with the exception of my spouse, parents, grandparents, children, siblings or employer
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 through Central KYC Registry or UIDAI or through any other modes 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 and 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/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.

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

PAYMENT DETAILS

Cheque ☐ Cheque Number _____ Drawn on _____ Dated: D D M M Y Y Y Y

(In favour of ICICI Lombard General Insurance Company Ltd.)

Credit Card ☐ Credit Card No. _____ Expiry date D D M M Y Y Y Y

Total amount in ₹ _____

Applicant Signature _____

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: _____

_____

_____

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: _____

TERMS & CONDITIONS AND SIGNIFICANT EXCLUSIONS

Receipt of proposal form by ICICI Lombard General Insurance Co. Ltd shall not be construed as acceptance of the proposal. The company in its sole discretion reserves the right to accept or reject any proposal without assigning any reason thereof.

Each of the events leading to a claim has a stated list of exclusions. The Proposer is requested to go through the Policy wordings for a complete list of these exclusions No amount under the policy shall be payable under the contingencies not covered. Additionally each of the events covered has a specific list of exclusions that are briefly listed here.

No benefit under the policy shall be payable for any major medical illness or procedure which results due to any pre-existing illness or symptom or which is diagnosed within 90 days of policy inception day.

Intentional Self injury, suicide, influence of alcohol, ionizing radiation, war The commencement of risk is subject to realization of full premium amount, receipt of satisfactory health status form and medical underwriting wherever applicable. In case of any claim made under the policy no premium shall be refunded on cancellation of the policy.

If the insured is already covered under any other policy of Secure Mind, kindly provide the Policy Nos:

Agent Confidentiality Report (To be signed by Agent/ SP) I, _____ (Full Name) in my capacity as the Specified Person of the Corporate Agent/Authorised Employee of the Broker/ Relationship Officer, do 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. I have also explained that the statement(s), information and response(s) submitted by him/her in this proposal form to questions contained

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.]