Enrolment form No._____

PROPOSAL FORM - SARAL SURAKSHA BIMA

FOR OFFICIAL USE ONLY

URN No.: PF/4187/00 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.

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

Proposer's Name:

Permanent Address :

Landmark:

City/Town: State: Pin Code:

Mailing Address :

Landmark:

City/Town: State: Pin Code:

Gender: Male ☐ Female ☐ Third Gender ☐ Date of Birth: D D M M Y Y Y Y Age (in years)

Mobile Number*: E-mail ID:

GSTIN No.: Pan No.:

Aadhar No.: LAN (If, applicable)

Are you an existing customer of ICICI Lombard, ☐ Yes ☐ No Are you an ICICI group employee? ☐ Yes ☐ No

If Yes, then kindly provide the policy number:

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.

INSURED DETAILS - PART B

Sr. No.	Insured Name	Date of Birth	Gender	Relationship with Proposer	Mobile No.	Email ID	GSTIN	Date from which insured person continuously obtaining Health Insurance in India	PED If any	ABHA No.

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

Note: Please provide an additional sheet if space is not sufficient to complete details.

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

Is any of the above insured person holding a Personal Accident Policy or a similar Health Cover from ICICI Lombard or Any Other Insurance Company? ☐ No ☐ Yes (Details to be provided in the below format)

Insured	Existing policy number	Existing Sum Insured	Claim Details, if any
Insured 1			
Insured 2			
Insured 3			
Insured 4			

Any Additional Information relevant to the policy being applied for:

TABLE OF BENEFITS - PART C

Kindly mention the Sum Insured against the covers for which insurance is required.

Customer can opt for one or more of the optional covers. All Base covers are compulsory.

Section	Cover	Sum Insured - Insured 1	Sum Insured - Insured 2	Sum Insured - Insured 3	Sum Insured - Insured 4
Base Covers	Death Due to Accident				
	Permanent Total Disablement				
	Permanent Partial Disablement				
Optional Covers	Temporary Total Disablement (per week for max up to 100 weeks)				
	Hospitalization Expenses due to Accident				
	Education Grant				

RISK DETAILS - PART D

Policy Start Date: D D M M Y Y Y Y End Date: D D M M Y Y Y Y Policy Tenure ☐☐☐☐

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 ☐☐☐☐

PREMIUM DETAILS - PART E

Total Premium (Incl. GST) _____

Mode of Payment _____ Premium _____

Premium payment mode Lumpsum ☐ Yearly ☐ Half-Yearly ☐ Quarterly ☐ Monthly ☐

Is policy on auto-renewal? ☐ Yes ☐ No Consent for ECS given? ☐ Yes ☐ No

Bank Name _____

Account No. _____ Account Type _____

Branch _____ MICR _____

IFSC _____

HEALTH & INCOME DECLARATION - PART F

I, hereby declare that none of the insured person listed in this form and intended to be covered under this policy suffer from Paralysis, Stroke (including any residual symptoms of an old stroke), Seizures/ Epilepsy and that none of them have any Physical Disability/ Deformity/ Amputation of Limb. I, also declare that the Sum Insured opted is not greater than ____ times of t he annual income of the respective insured person (This shall be subject to preva lent UW guidelines & sha ll be modified accordingly).

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

GENERAL DECLARATION - PART G

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 aut horized 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 or during the policy period.
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 incl uding 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 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.
7. I/We hereby declare and confirm that t he premium has been paid out of legally acquired sources of income and th e subsequent premiums if any will continue to be paid out of legally declared and assessed source of income.
8. I/We hereby declare that the details furn ished above are true and correct to the best of my/our knowledge and bel ief and I/we undertake to inform you of any changes therein, immediately and not later than 30 days.
9. In case any of th e 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.
10. I/We understand that the Company has right to call for documents to establish source of funds.

Date D D M M Y Y Y Y Place _____ 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: _____

Declaration in case of Premium payment on installment basis

I hereby declare that I have opted for payment of premium towards this policy on instalment basis and I hereby consent for the following:

i. Installment premium shall be collected on Monthly Quarterly Half-Yearly Yearly basis
from D D M M Y Y Y Y to D D M M Y Y Y Y

ii. In case of in sta llment premium being paid through ECS mode, I shall provide a consent for the same on an ECS mandate form and shall attach the same with this application.

iii.I have been informed that the t otal premium shall be INR _____ and accordingly, the premium towards each installment shall be INR _____

iv.I have been informed that upon non-payment of any premium instalments for up to 7 days from the due date of such installment thereof this Policy shall cease to operate from the time and date of the default in payment of such premium instalment.

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: _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _