SPECIAL SHIELD

GUIDELINES FOR COMPLETION OF THE FORM

- This policy is specially designed for Persons with Disability and Persons with HIV/AIDS.
  a. Persons with Disability shall be covered if 40% disability is certified by the Medical Board appointed by the government for certifying Disability as per the Disability Act 2016.
  b. Persons who are HIV/ AIDS positive Individuals with CD4 count above 500 in the past 36 months prior to policy issuance.
- Please answer all questions correctly and completely.
- Information for fields marked with asterisk (*) are mandatory.
- Only Indian Nationals can be covered under this policy.
- Note: The Coverage proposed for insurance is not covered until the proposal is accepted and premium is paid and the same is realized by ICICI Lombard General Insurance Company.

For Official Use Only

Product Code: Proposal No. : Code/Functional Identity:

Intermediary Name & Specified Person Name / Principal Officer Name:

Branch/Office: Deal No.:

Email ID of the branch: Contact No. of the branch:

PROPOSER DETAILS*

Name

Communication Address

City State

Landmark Pin Code

Phone E-mail ID.

Profession Salaried Self-Employed Other

Occupation and Nature of Business / Work

PAN No./ form 60/61

Mobile No. Date of Birth D D M M Y Y Y Y

Gender Male Female Third Gender CKYC

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

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.

COVERAGE DETAILS

Policy Type I N D I V I D U A L B A S I S Policy period 1 Y E A R

Period of Insurance From D D M M Y Y Y Y To D D M M Y Y Y Y

Sum Insured Rs. 4 Lakhs Rs. 5 Lakhs

Coverage opted Pre-existing HIV/AIDS Pre-existing Disability Pre-existing HIV/AIDS and Disability

Waiver for Co-payment opted Yes No

DETAILS OF PERSONS TO BE INSURED

Sr No	Name of the Insured	Nationality	Date of Birth	Age	Gender	Height	Weight	Occupation	Marital Status	Relation with Proposer	ABHA No.
1											

I agree to share my medical records with insurers ICICI Lombard / TPA through ABHA: ☐ Yes ☐ No

Please generate your ABHA No. by visiting the official website ndhm.gov.in and share the same with us.

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				

PREVIOUS/EXISTING HEALTH DETAILS OF INSURED

Do you suffer from HIV/AIDS?	☐ Yes ☐ No	If Yes, please enclose a recent certificate of your current CD4 count (within past 30 days)
Current CD 4 count		
Has your CD4 Count gone below 500 in the past 4 years?	☐ Yes ☐ No If yes when and How many times	
Do you suffer from any other illness/ disease related to/arisingof/associated to HIV/AIDS?	☐ Yes ☐ No	If Yes, please give details:
Do you suffer from any disability as per the listed conditions mentioned below	☐ Yes ☐ No	If Yes, please enclose Disability certificate mentioning percentage of disability wherever applicable.

1. Blindness ☐	2. Muscular Dystrophy ☐
3. Low vision ☐	4. Chronic Neurological conditions ☐
5. Leprosy Cured persons ☐	6. Specific Learning Disabilities ☐
7. Hearing Impairment (deaf and hard of hearing) ☐	8. Multiple Sclerosis ☐
9. Locomotor Disability ☐	10. Speech and Language disability ☐
11. Dwarfism ☐	12. Thalassemia ☐
13. Intellectual Disability ☐	14. Haemophilia ☐
15. Mental Illness ☐	16. Sickle Cell disease ☐
17. Autism spectrum disorder ☐	18. Multiple Disabilities including deaf/ blindness ☐
19. Cerebral Palsy ☐	20. Acid Attack victim ☐
21. Parkinson's disease ☐	

Do you suffer from any pre-existing illness other than Disability or HIV AIDS mentioned above? ☐ Yes ☐ No

If Yes, please specify details and the no of years you are suffering _____

Do you have any other physical disability arising out of any illness/disease condition? _____

Any other previous medical details _____

PREVIOUS/EXISTING HEALTH INSURANCE DETAILS

Policy No. / Application No.	Insurer Name	Period of Insurance (from – to)	Sum Insured	Claims lodged during the preceding years

Please provide us the details of other policies to enable us to co ordinate with other insurer at the time of claim to settle the balance claim amount in case sum insured in this policy is exhausted.

Do you have the same policy from any one or other insurer? ☐ Yes ☐ No

If Yes, Please share details below: _____

Policy No. / Application No.	Insurer Name	Period of Insurance (from – to)	Sum Insured	Claims lodged during the preceding years

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)

ELECTRONIC INSURANCE ACCOUNT DETAILS SECTION

I want _____ related information in –

Physical Format- ☐ Yes ☐ No e-Format (electronic) as & when applicable- ☐ Yes ☐ No

Choose your Insurance Repository (For those selecting e-Format)

(a) NSDL Data Management Ltd.

(b) CDSL Insurance Repository Ltd

© Karvy Insurance Repository Ltd.

(d) CAMS Repository Services Ltd

I have e Insurance Account & the No. is _____

My CKYC No. (Central Know Your Customer registry number) is (If available) _____

Do you wish to avail a physical copy of your policy documents? Yes ☐ No ☐

PREMIUM PAYMENT DETAILS

Name of Premium payer	
Premium Payment Frequency	☐ Monthly ☐ Quarterly ☐ Half Yearly
Premium Amount(in INR)	

Instrument Type ☐ Cash ☐ Cheque ☐ Debit Card ☐ Credit Card ☐ Others: Please Specify _____

Date D D M M Y Y Y Y

Cheque no.

Bank Name

Bank Account No.

IFSC Code

Branch Name

BANK ACCOUNT DETAILS FOR PROCESS OF REFUND

Cheque will be issued in the name of the Proposer only.

In case of cancellation of policy, if premium was paid through credit card the refund amount would be credited to Credit Card account directly or refund will be paid through cheque. Please provide the following bank details and a copy of Cancelled Cheque if you opt for direct credit of refund/ claim into your bank account:(Cancelled Cheque should be of the same bank account in which the refund needs to be credited directly.

Name of Account holder	
Cheque No	
Bank Name	
Branch Name	
Cheque Date	
Cheque Amount for ₹	
Name as in Bank Account	
Bank Account No	
IFSC Code	
MICR Code	

Note: The Proposer agrees and undertakes to intimate in writing to ICICI Lombard about any change in bank account details.

If ECS is selected, please submit the standing instruction form available at our branches.

Date D D M M Y Y Y Y

Place :

Signature of the Proposer

NOMINEE BANK ACCOUNT DETAILS FOR PROCESS OF REFUND

Cheque will be issued in the name of the Proposer only.

In case of cancellation of policy, if premium was paid through credit card the refund amount would be credited to Credit Card account directly or refund will be paid through cheque. Please provide the following bank details and a copy of Cancelled Cheque if you opt for direct credit of refund/ claim into your bank account:(Cancelled Cheque should be of the same bank account in which the refund needs to be credited directly.

Name of Account holder	
Cheque No	
Bank Name	
Branch Name	
Cheque Date	
Cheque Amount for ₹	
Name as in Bank Account	
Bank Account No	
IFSC Code	
MICR Code	

Note: The Proposer agrees and undertakes to intimate in writing to ICICI Lombard about any change in bank account details.

If ECS is selected, please submit the standing instruction form available at our branches.

Date D D M M Y Y Y Y

Place :

Signature of the Proposer

AML GUIDELINES

I/ We hereby confirm that all premiums have been/ will be paid from bonafide sources and no premiums have been/ will be paid out of proceeds of crime related to any of the offence listed in Prevention of Money Laundering Act 2002. I/We understand that the Company has the right to call for documents to establish source of funds. The insurance Company has the right to cancel the insurance contract in case I am/ have been found guilty by any competent court of law under any statues, directly or indirectly governing the prevention of money laundering in India.

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 & WARRANTY ON BEHALF OF ALL PERSONS PROPOSED TO BE INSURED

I. I/We hereby declare on my behalf and on behalf of all persons proposed to be insured that the above statements 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 insurance policy, is subject to the Board approved under writing policy of the Insurance company and that the policy will come into force only after full receipt to 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/proposer after the proposal has been submitted but before communication of the risk acceptance by the company.

iv. I/We declare and further consent to the company. Seeking medical information from any hospital who at any time has attended on the life to be insured/proposer or from any past or present employer concerning anything which affects the physical and mental health of the life to be assured/proposer and seeking information from any insurance company to which an application or 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 Governmental and/or Regulatory Authority.

vi. I/We aware of premium loading, (if any declared above) for habit's & diseases as declared / mention by me/ us above.

vii. I/ We hereby agree to keep record of KYC details of all the individual members covered under the group insurance, and ensure to provide the details of beneficiaries to the Company as and when required.

viii. 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 .

xi. 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.

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

xi. 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.

xii. 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.

VERNACULAR DECLARATION

** Applicable where the Proposer is illiterate or is suffering from a disability due to which writing is restricted or where the Proposer has signed in vernacular language. (Note: The below must be witnessed by someone other than the Advisor/Employee of the Company).

I/We certify that the product applied for by me/us and the contents of the Proposal Form have been clearly explained to me/us and I/we have fully understood them. I/We further certify that the replies in the Proposal Form have been recorded as per the information provided by me/us. I, (Full name of the witness)_____(Relation with the Proposer)_____adult and inhabitant of (city)_____and residing at_____do hereby certify that I have read out and explained the contents of the Proposal Form and all other documents incidental to availing the insurance policy from ICICI Lombard Ltd., to the Proposer and he/she/they have understood the same. I/we declare that whatever I/we have stated herein above is true and correct to the best of knowledge and belief.

Date D D M M Y Y Y Y

Place : _ _ _ _ _ _ _ _ _ _ _ _

Signature/Thumb impression of the Proposer/Primary Insured	Signature of the Witness

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:*

(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.*