ICICI Lombard
Nibhaye Vaade

Proposal Form No. (For Official Use Only): _____

SP certification code: _____

Annexure 6

VOYAGER TRAVEL INSURANCE (GROUP)

URN NO. PF/4168/01

MO EMP ID _____ Business sector: Urban ☐ Rural ☐

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 issued 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 misrepresentation, or established fraud or non-disclosure by the Insured or anyone acting on his behalf to obtain any benefit under this Policy.
4. Kindly contact the 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.

Details of Proposer/ Policy Holder:

Proposer's Name (First) (Middle) (Last)

Mr./ Ms./ Dr.:

Date of Birth: D D / M M / Y Y Y Y Sex: Male ☐ Female ☐ Third Gender ☐ Marital Status: Married ☐ Unmarried ☐

Status (please tick any one): Private Limited Co. ☐ Public Ltd. Co. ☐ Unincorporated Association ☐ or Body of Individuals ☐ Partnership/LLP ☐

Trust/ Foundation ☐ NGO/NPO ☐ Government ☐ Others (please specify) ☐ CKYC no.

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

Correspondence Address:

City: State:

Pin code: ABHA No.

Telephone Number (with STD Code): Fax (with STD Code):

Mobile Number: Email:

Details of Insured Person(s)

Number of Insured Persons/beneficiaries in the Group: (Please mention details of ALL the persons proposed to be insured under the policy)

Particulars	Details
Name of the Insured	
Gender of the Insured	
Date of birth of the Insured	
Age as on Policy Start Date	
Relationship of Insured with Proposer	
Mailing address of the Insured	
Occupation	
Income per annum	
Mobile Number	
Email ID	
Passport Number	
Country of Issue of Passport	
Resident Status	
PAN Number / National ID No.	
ABHA No.	
Pre-Existing Disease (if any):	
For Student Travel policies, i. Name of Educational Institute in which Insured is enrolled ii. Name of the educational course in which Insured in enrolled	

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

Are you or any of the proposed applicants/beneficial owner a PEP* or a Family member/ Close relatives/Associates of PEPs? Yes ☐ No ☐

If yes, explain nature of relationship and position held by PEP: _____

*Politically Exposed Persons (PEPs) are individuals who are or have been entrusted with prominent public functions in a foreign country, e.g., Heads of States/Governments, senior politicians, senior government/judicial/military officers, senior executives of state-owned corporations, important political party officials, etc.

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

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				

DETAILS OF APPOINTEE (Details to be filled only if nominee is a minor)

	1st Appointee	2nd Appointee	3rd Appointee	4th Appointee
Name of Appointee				
Date of Birth of Appointee	DD/MM/YYYY	DD/MM/YYYY	DD/MM/YYYY	DD/MM/YYYY
Percentage of Nomination	_____%	_____%	_____%	_____%
Relation of the Appointee with the Insured				
Mobile No.				
Eamil ID				
Present Address				
Permanent Address				

3. Travel Details:

a. Purpose of visit: Business / Leisure / Student / Religious / Others (Please specify) _____

b. Geographical Scope of Cover:

c. Type of Trip: Single-trip / Round-trip / Multi-trip

d. Details of Trip:

1	From Place of Origin	D D / M M / Y Y	To Destination	D D / M M / Y Y	No. of Days	
2	From Place of Origin	D D / M M / Y Y	To Destination	D D / M M / Y Y	No. of Days	
3	From Place of Origin	D D / M M / Y Y	To Destination	D D / M M / Y Y	No. of Days	
4	From Place of Origin	D D / M M / Y Y	To Destination	D D / M M / Y Y	No. of Days	
5	From Place of Origin	D D / M M / Y Y	To Destination	D D / M M / Y Y	No. of Days	

e. Mode of travel (Please mention mode of travel for all parts of the trip): _____

f. Common Carrier opted for Trip: _____

g. Adventure sports Activities to be undertaken while on trip? _____ Select from the list provided in Annexure - I

h. Detailed Travel Itinerary of the Insured:

i. Please provide the details of past travel insurance policies:

Sr. No	Policy Period	Insurance Company	Product name	Date of issuance of First Policy	Premium s Paid	Claims
1						
2						
3						
4						
5						
6						

Coverage Details:

a. Type of Trip: Single-trip / Round-trip / Multi-trip

b. Coverage Required: Please put a tick against the covers opted. Also mention the deductibles against the Covers, wherever applicable.

Section and Coverage	Sum Insured	Indemnity / Benefit	Deductible, if any	Franchise, if any	Co-Pay, if any	Cover-specific Condition, if any
SECTION 1: MEDICAL EXPENSES FOR ACCIDENTAL INJURY						
1. Hospitalization Expenses for Injury						Sub-limits* -
1. a. Outpatient Treatment for Injury						
1. b. Medical Aid Cover						Medical Aids being covered - _____
2. Daily Allowance in case of Hospitalization due to Injury	Rs._____ per day for maximum upto _____ no. of days					
3. Child care expenses due to Injury	Rs._____ per day for maximum upto ____ no. of days					
SECTION 2 : MEDICAL EXPENSES FOR HOSPITALIZATION						
Section and Coverage	**Sum Insured**	**Indemnity / Benefit**	**Deductible, if any**	**Franchise, if any**	**Co-Pay, if any**	**Cover-specific Condition, if any**
4. Hospitalization Expenses for Illness and Injury						Sub-limits* -
4. a. Outpatient Treatment for Illness and Injury						
4.b. Pre-Existing Disease Cover						
4.c. Medical Aid Cover in case of Illness and Injury						Medical Aids being covered - _____
4.d. Maternity Cover	Sum Insured - _____ Pre-natal check-up Sum Insured Limit - _____					
5. Daily Allowance in case of Hospitalization	Rs._____ per day for maximum upto ____ no. of days					
6. Child care expenses due to Hospitalization	Rs._____ per day for maximum upto ____ no. of days					
SECTION 3 : OTHER MEDICAL COVERS						
Section and Coverage	**Sum Insured**	**Indemnity / Benefit**	**Deductible, if any**	**Franchise, if any**	**Co-Pay, if any**	**Cover-specific Condition, if any**
7. Lifestyle/Wellness (Covers Opted : _____ _____ _____ _____	*Sum Insured per cover opted*					Sub-limits per cover No. of consultations per cover – Sub-limits* -
8. Repatriation of Remains						
9. Medical Evacuation						
10. Dental Treatment						

SECTION 4 : NON-MEDICAL COVERS						
Section and Coverage	**Sum Insured**	**Indemnity / Benefit**	**Deductible, if any**	**Franchise, if any**	**Co-Pay, if any**	**Cover-specific Condition, if any**
11. Political Risk and Catastrophe Evacuation	Rs._____ per day for maximum upto ____ no. of days					
12. Loss of Checked-in Baggage						
12.a. Electronic Equipment Loss	Sum Insured – Per article Sum Insured limit -					
12.b. Sports Equipment Loss						
13. Damage to Baggage during Transit						
14. Delay of Checked-in Baggage						
15. Loss of Baggage and Personal Effects						
15.a. Loss of Electronic Equipment	Sum Insured – Per article Sum Insured limit -					
15.b. Loss of Valuables including Personal Money						
15.c. Loss of Travel Documents						
15.d. Loss of Sports Equipment						
16. Personal Accident						
16.a. Coma Cover	Sum Insured per week – Max no. of weeks -					
16.b. Child Benefit Cover						
16.c. Workplace Assault						
16.d. Child Education Grant						
17. Accidental Death and Disablement (Common Carrier/Public Carrier)						
18. Personal Liability						
18.a. Court Attendance Cover						
19. Hijack Distress Compensation	Rs. _____ per day or lumpsum SI : Rs. _____					
20.a. Financial Emergency Cash Allowance (Lumpsum)	SI: Rs. _____					
20.b. Financial Emergency Cash Allowance (Per Day Basis)	Rs._____ per day for maximum upto _____ no. of days					
21. Trip Cancellation						No. of trips being covered -
21.a. Frequent Flyer points						
21.b. Event Cancellation Cover						
21.c. Reimbursement of Cancellation charges of pre-booked events						
22.a. Trip Cancellation due to Visa Rejection						
22.b. Refund of Visa Fee						

SECTION 4 : NON-MEDICAL COVERS						
Section and Coverage	**Sum Insured**	**Indemnity / Benefit**	**Deductible, if any**	**Franchise, if any**	**Co-Pay, if any**	**Cover-specific Condition, if any**
23. Trip Interruption or Curtailment						
23.a. Trip Resumption						
23.b. Reimbursement of cancellation charges of pre-booked events						
24. Cancellation Cover for Hotel and Accommodation						
25. Cancellation Cover for Common Carrier/Public Carrier						
26. Operator Driven Common Carrier/Public Carrier Cancellations	Sum Insured applicable to ticket – Sum Insured applicable for hotel/transport -					
27. Mismatch in Carrier						
28. Trip cancellation Plus – Common Carrier/Public Carrier						Journey Start Time -
29. Trip Cancellation Plus - Hotels / Other Accommodation						
30.a. Common Carrier/Public Carrier Delay						Time before which Common Carrier/Public Carrier should inform about delay - ___ Hours
30.b. Lounge Access / Recreation Cover for Common Carrier/Public Carrier Delay						
31. Missed Connecting Common Carrier/Public Carrier						
32. Fire and Allied Perils (Home Building & Contents)						
33. Burglary (Home Contents)						
34. Compassionate Visit						
35. Escort of Minor Children						
36. Bounced Bookings of Airlines or Hotel						
37. Hotel Extension due to Contingency						
38. Automatic Extension of Period of Insurance						
39. Loss of Passport/International Driving License						
40. Golfer's Hole in One						
41. Car Rental Cover						
41.a. Rental Vehicle Return						
42. Bail Bond						
43. Cruise Cover						
43.a. Medical Cover while on a cruise						
43.b. Missed Shore Cover						
44. Kidnap Distress Allowance						
45. Replacement and Rearrangement of Staff						

SECTION 4 : NON-MEDICAL COVERS						
Section and Coverage	**Sum Insured**	**Indemnity / Benefit**	**Deductible, if any**	**Franchise, if any**	**Co-Pay, if any**	**Cover-specific Condition, if any**
46. Student Sponsor Protection						
47. Study Interruption						
48. Adventure Sports Cover						Level 1 / Level 2 / Level 3
48.a. Level 1 Cover						
48.b. Level 2 Cover						
48.c. Level 3 Cover						
49. Pet Care Cover Policy wide extension – Travel by a Self-driven Carrier Value Added Services						

COVERAGE TABLE – FOR DOMESTIC POLICY

Section and Coverage	Sum Insured	Indemnity / Benefit	Deductible, if any	Franchise, if any	Co-Pay, if any	Cover-specific Condition, if any
SECTION 1: MEDICAL EXPENSES FOR ACCIDENTAL INJURY						
1. Hospitalization Expenses for Injury						Sub-limits* -
1. a. Outpatient Treatment for Injury						
1.b. Medical Aid Cover covered - _____						Medical Aids being
2. Daily Allowance in case of Hospitalization due to Injury	Rs._____ per day for maximum upto ____ no. of days					
3. Child care expenses due to Injury	Rs._____ per day for maximum upto ____ no. of days					
SECTION 2 : MEDICAL EXPENSES FOR HOSPITALIZATION						
Section and Coverage	**Sum Insured**	**Indemnity / Benefit**	**Deductible, if any**	**Franchise, if any**	**Co-Pay, if any**	**Cover-specific Condition, if any**
4. Hospitalization Expenses for Illness and Injury						Sub-limits* -
4. a. Outpatient Treatment for Illness and Injury						
4.b. Medical Aid Cover in case of Illness and Injury						Medical Aids being covered - _____
5. Daily Allowance in case of Hospitalization	Rs._____ per day for maximum upto ____ no. of days					
6. Child care expenses due to Hospitalization	Rs._____ per day for maximum upto ____ no. of days					
7. Repatriation of Remains						
8. Medical Evacuation						
9. Dental Treatment						

SECTION 3 : OTHER MEDICAL COVERS						
Section and Coverage	**Sum Insured**	**Indemnity / Benefit**	**Deductible, if any**	**Franchise, if any**	**Co-Pay, if any**	**Cover-specific Condition, if any**
SECTION 4 : NON-MEDICAL COVERS						
Section and Coverage	**Sum Insured**	**Indemnity / Benefit**	**Deductible, if any**	**Franchise, if any**	**Co-Pay, if any**	**Cover-specific Condition, if any**
10. Political Risk and Catastrophe Evacuation	Rs._____ per day for maximum upto ____ no. of days					
11. Loss of Checked-in Baggage						
11.a. Electronic Equipment Loss	Sum Insured – Per article Sum Insured limit -					
11.b. Sports Equipment Loss						
12. Damage to Baggage during Transit						
13. Delay of Checked-in Baggage						
14. Loss of Baggage and Personal Effects						
14.a. Loss of Electronic Equipment	Sum Insured – Per article Sum Insured limit -					
14.b. Loss of Valuables including Personal Money						
14.c. Loss of Travel Documents						
14.d. Loss of Sports Equipment						
15. Personal Accident						
16. Accidental Death and Disablement (Common Carrier/Public Carrier)						
17. Trip Cancellation						No. of trips being covered -
17.a. Frequent Flyer points						
17.b. Event Cancellation Cover						
17.c. Reimbursement of Cancellation charges of pre-booked events						
18. Trip Interruption or Curtailment						
18.a. Trip Resumption						
18.b. Reimbursement of Cancellation charges of pre-booked events						
19. Cancellation Cover for Hotel and Accommodation						
20. Cancellation Cover for Common Carrier/Public Carrier						
21. Operator Driven Common Carrier/Public Carrier Cancellations	Sum Insured applicable to ticket – Sum Insured applicable for hotel/transport -					
22. Mismatch in Carrier						

SECTION 4 : NON-MEDICAL COVERS						
Section and Coverage	**Sum Insured**	**Indemnity / Benefit**	**Deductible, if any**	**Franchise, if any**	**Co-Pay, if any**	**Cover-specific Condition, if any**
23. Trip Cancellation Plus – Common Carrier/Public Carrier						Journey Start Time -
24. Trip Cancellation Plus – Hotels / Other Accommodation						
25.a. Common Carrier/Public Carrier Delay						Time before which Common Carrier/Public Carrier should inform about delay - ___ Hours
25.b. Lounge Access / Recreation Cover for Common Carrier/Public Carrier Delay						
26. Missed Connecting Common Carrier/Public Carrier						
27. Fire and Allied Perils (Home Building and Contents)						
28. Burglary (Home Contents)						
29. Compassionate Visit						
30. Escort of Minor Children						
31. Hotel Extension due to Contingency						
32. Automatic Extension of Period of Insurance						
33. Car Rental Cover						
33.a. Rental Vehicle Return						
34. Adventure Sports Cover						Level 1 / Level 2 / Level 3
34.a. Level 1 Cover						
34.b. Level 2 Cover						
34.c. Level 3 Cover						
35. Pet Care Cover Policy wide extension – Travel by a Self-driven Car Value Added Services						

Adventure Sports

Whether involved in Adventure Sports activities: Training or Participation in competitions of professional or semi-professional nature: YES ☐ NO. ☐

If YES, Level 1 / Level 2 / Level 3 (Please refer to the Policy Wordings for determining the level)

Additional details: _____

Period of Insurance

For Single-trip:

Journey Start Date D D / M M / Y Y Journey End Date D D / M M / Y Y Total number of days ☐☐☐

For Round-trip:

Journey Start Date D D / M M / Y Y Journey End Date D D / M M / Y Y Total number of days ☐☐☐

For Multi-trip:

Date of Commencement of Insurance D D / M M / Y Y Date of Expiry of Insurance D D / M M / Y Y

Bank Account Details

	Bank Details of insured	Bank Details of Nominee	Bank Details of Appointee
Beneficiary Name			
Bank Name			
Bank Account Number			
IFSC CODE			
MICR NUMBER			
BRANCH			

Payment Details

(Please tick the appropriate option and fill the amount details)

Cash ☐ Cheque ☐ Credit Card ☐ Premium Amount Rs. _____

Cheque No. / Credit Card No. ☐☐☐☐☐☐☐☐☐☐ Cheque Date D D / M M / Y Y Branch (if cheque) ☐☐☐☐☐☐☐☐☐☐☐

Bank Name / Credit Card Name ☐☐

Name of Bank Account Holder / Credit Card Holder ☐☐

IFSC Code* ☐☐☐☐☐☐☐☐☐☐ MICR ☐☐☐☐☐☐☐☐☐☐ Account Number ☐☐☐☐☐☐☐☐☐☐

Account type Savings ☐ Current ☐ Cash ☐ Credit ☐ Overdraft ☐

*Please enclose cancelled cheque along with the Proposal 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

Any additional information relevant to the policy applied for

Note: Please use additional sheets if space is not sufficient to complete details

Declaration

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 authorised 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 I 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.
4. I declare that I consent to the company seeking medical information from any doctor or hospital who/which at any time has attended on the person to be insured/proposer or from any past or present employer concerning anything which affects the physical or mental health of the person to be insured/proposer and seeking information from any insurer to whom an application for insurance on the person to be insured /proposer 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/proposer for the sole purpose of underwriting the proposal and/or claims settlement and with any Governmental, Judicial and/or Regulatory authority.

Additional Declarations:

6. I have been provided with the detailed terms of the policy. I have read, understood and aware of the detailed 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 hereby confirm that I have insurable interest in the policy and the premium is not borne by any third party entity or person.
9. 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.
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. I 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.

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.

Proposer's Name: ☐☐☐☐☐☐☐☐☐ (First) ☐☐☐☐☐☐☐☐☐☐☐ (Middle) ☐☐☐☐☐☐☐☐☐☐ (Last) ☐☐☐☐☐☐☐☐

Date: D D / M M / Y Y Y Y Place: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ Proposer's Signature _____

Declaration when the proposal form is filled by a person other than the proposer / the proposer signs in a vernacular language / proposer is illiterate

I hereby declare that I have read out and explained the content of this proposal 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 proposal 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: _____

INTERMEDIARY DECLARATION AND DETAIL/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) Ware 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 Sec 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.

2) Any person making default in complying with the provisions of this section shall be liable for a penalty, which may extend to ten lakhs.

ICICI Lombard Nibhaye Vaade

ICICI Lombard General Insurance Company Limited

Mailing Address: Interface Building No. 16, 601-602, 6th Floor, New Link Road, Malad (West), Mumbai - 400 064.
Registered Office Address: ICICI Lombard House, 414, Veer Savarkar Marg, Near Siddhi Vinayak Temple, Prabhadevi, Mumbai 400 025.
Visit us at www.icicilombard.com • Mail us at customersupport@icicilombard.com • Toll Free No.: 1800 2666 • **Chargable No.:** +91 86 55 222 666
Insurance is the subject matter of solicitation. IRDA Reg. No. 115. • **CIN:** L67200MH2000PLC129408