ACKO GROUP HEALTH INSURANCE POLICY

PROPOSAL FORM

NOTE: This form is to be completed by the Group/ Association/ Institution/ Corporate Body. We are under no obligation to accept any proposal for insurance. The liability of the Company does not commence until this proposal is accepted by the Company and premium is received in full.

Please ensure that the information in this form material for assumption of risk is true, accurate and complete in all respects as inaccuracy or non-disclosure of the requested information or other material facts could preclude recovery of any claim under the policy.

Please complete this form in CAPITAL LETTERS. The proposal form is to be submitted in original, copies shall not be accepted.

FOR OFFICE USE

Branch Name: _____ **Branch Code:** _____
Intermediary Name: _____ **Intermediary Code:** _____
Business Type: _____ **Channel Type:** _____
Proposal Form No.: _____ **Intermediary Contact:** _____

I. PROPOSER (GROUP) DETAILS:

All invoices will be raised to the following address and addressed to the principal contact person specified below.

Proposed Policy Period From: DD/MM/YYYY To: DD/MM/YYYY

- Proposer Name: _____
- Description of the Proposer's Business: _____
- Principal Contact Person Name: _____
- Correspondence Address: _____
  City: _____State: _____ Pin Code: _____
- Telephone Number: Mobile: _____ Office (*Optional*): _____
  E-mail: ID 1 _____ ID 2 _____
- Pan No. / TAN No.: _____ (*Mandatory for premium of INR 50,000 and above if accepted in Cash/Demand Draft, or INR 100,000 and above by Cheque/Credit Card/Debit Card*)
- Customer Goods & Service Tax Identification Number (*if any*): _____
- Mode of Payment: _____
- Frequency of Payment: Monthly / Quarterly / Half Yearly / Yearly

- Nature of Group: Employer/employee OR Non-employer/employee
- Description of the Group to be insured: _____

- Nature of Policy: Named basis OR Unnamed basis
- Nature of Travel: _____ (Air, Rail, Road, etc.)
- Please state whether all eligible Insured Persons/families of the Group / Association / Institution / Corporate Body are proposed for insurance? Yes _____ No _____

II. DETAILS OF PREVIOUS INSURER(S) (IF RENEWAL):

- Are your employees/ Insured Persons at present insured under any Group Health Insurance/Travel Insurance Policy? Yes ___ No ___ (*If 'Yes' Please provide the details insurer, type of policy with coverage & sum insured - attach additional sheet if required*)

- Name of Insurer: _____
- Policy Number: _____
- Expiring terms of cover: _____
- Period of insurance: _____
- Premium paid: _____
- Claim details: (*Please attach separate sheet providing complete details of claims with individual claim records*)

- Incurred Claims Ratio: _____

III. DETAILS OF INSURED PERSONS

Note: *1. This list will be attached to and forming part of the proposal form and policy to be issued.*
2. Separate list should be attached in respect of persons proposed to be covered under each Sum Insured.
3. All nominations will be in accordance with Section 39 of the Insurance Act 1938.
4. A Minor should not be declared as nominee.

Coverage Category	No. of Employees	No of Members
Category A*		
Category B*		
Total		

A and B might be defined within a group, depending on the seniority, nature of work etc.
For Named member / Employees: Fill the Annexure 1
Please attach additional sheets, if space not sufficient to complete details.

IV. BENEFITS:

Category	Basis of Coverage (Individual/Floater)	Floater Unit (in case of Floater)	Selected Benefits
Category A			Refer Annexure II.A
Category B			Refer Annexure II.B

Note: *All the benefits can be chosen for the category. Please select the benefits that you wish to avail* as per Annexure 2

V. DECLARATION & AUTHORISATION

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 mode of travel, 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 travel information from the travel organizer, service provider or 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 mode of travel, incident details, loss or inconvenience caused to the insured, the medical records of the insured/proposer for the sole purpose of underwriting the proposal and/or claims settlement and with any Governmental and/or Regulatory authority.

I submit that the foregoing information is true to the best of my knowledge, and accept that if found to be untrue in any form, the Company reserves the right to alter/ cancel the coverage available under this Policy.
Note: The liability of the Company does not commence until full premium has been realized by the Company and the acceptance of the proposal has been formally intimated to the insured.

Principle Contact Person Name: _____

Date: _____ Signature of the Proposer: _____

Place: _____

VI. SALES PERSON/INSURANCE AGENT/INTERMEDIARY DECLARATION

I, _____(Full Name) in my capacity as an insurance Agent/ Specified Person of the Corporate Agent/authorized employee of the Broker or authorized Sales Person of the Company, 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 vary the benefits which may be payable and further more if there has been a non-disclosure of any material fact, the Policy issued to his/her favour pursuant to this Proposal may be treated by the Company as null and void and all premiums paid under the Policy may be forfeited to the Company.

License No. / ID (*Agent / Corporate Agent / Broker / Sales Person*): _____

Date: _____ Signature of Proposer/ Intermediary: _____
Place: _____

VII. PROHIBITION OF REBATES (SECTION 41 OF INSURANCE ACT, 1938, AS AMENDED)

1. No person shall allow or offer to allow, either directly or indirectly, as an inducement to any person to take out 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 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 prospectus or tables of the insurers.

2. Any person making default in complying with the provisions of this section shall be liable for penalty which may extend to 10 lakh rupees.

Annexure *1:

Sr No	Name of Insured Person	Unique Employee No/Customer Relationship number	Relationship of family with primary Insured	Date of Enrolment/ Joining	Age	Gender	Nominee Name & Relationship with Insured Person	Mobile No. & Email ID	Coverage Category	Address of the Insured
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Note: *This list is indicative and details could be modified according to the Nature of Group/ Policy.

Annexure 2:

Please provide details pertaining to sum insured or conditions opted for each benefit and enter "None" for Cover Benefits not opted for

Benefits selected for Category <Name>

1. In-patient Indemnity Benefits

Sr No.	Name of the Benefit	Event Covered (Illness/Injury)	Sum Insured / Sub-Limit	Other Conditions (Provide Details)
1	In-Patient Hospitalization Cover			
2	Worldwide In-Patient Hospitalization Cover			
3	In-Patient Hospitalization Fixed Benefit			Min. days of hospitalization required: _____
4	Daily Hospital Cash		Rs ____ per day	Min. no of days____ Max. no. of days____
5	Day Care Treatment Cover			
6	Road Ambulance			
7	Compassionate Visit			Min. days of hospitalization required: _____
8	Compassionate Visit Stay		Rs ____ per day	Min. no of days____ Max. no. of days____
9	Loss of Pay due to Hospitalization		Rs ____ per Month	Max. no. of days/Months____
10	EMI Protection		EMI amount: Rs __ Sum Insured: ___	Max. no. of days/Months____
11	Missed Bill Payment			
12	Hardship Allowance			
13	Income Protection Plan		Rs ____ per day	Min. no of days____ Max. no. of days____
14	Maternity			
15	New Born Baby Medical Expenses			
16	Pre-Post Natal			
17	Vaccination			
18	Repatriation of Moral Remains			
19	Funeral Expenses			

2. In-patient Indemnity Benefits (Cover Options)

Sr No.	Name of the Cover Option	Event Covered (Illness/Injury)	Sum Insured / Sub-Limit	Other Conditions (Provide Details)
1	Room Rent Limits / Room Type Options		___% of SI or Rs ____	Room Category: _____
2	ICU Limits		___% of SI or Rs ____	
3	Pre and Post Hospitalization Medical Expense Cover			Max. no. of days for Pre & Post Hospitalization __/___
4	Domiciliary Treatment Cover			Min. no of days____ Max. no. of days____
5	Donor Expenses			
6	Daily Cash for choosing lower category room		Rs _____ per day	
7	Sub-Limits for Specific Condition			

Sr No.	Name of the Cover Option	Event Covered (Illness/Injury)	Sum Insured / Sub-Limit	Other Conditions (Provide Details)
8	Restoration of Sum Insured		__% of Sum Insured	Limited to __ time(s) per year
9	Cumulative Bonus		__% of Sum Insured	Max. limit __% of Sum Insured
10	Additional Buffer Sum Insured for the Group			
11	Annual Aggregate Deductible			Deductible Amount: ____
12	Per Claim Deductible			Deductible Amount: ____
13	Group Deductible			Deductible Amount: ____
14	Reimbursement Only Cover			
15	First notification of claim (FNOC) Cover			Co-Pay %: ____
16	Network limited to specified geographies			Co-Pay %: ____
17	Network limited to preferred providers			Co-Pay %: ____
18	Coverage Continuity in case of Pink Slip			
19	Rewards for Healthy Behaviour			
20	Expert Opinion			
21	Healthy Pregnancy Program			
22	Child Protect Cover			
23	Sleep Apnea Cover			
24	Septoplasty Cover			
25	Gender Affirmation/ Reassignment Surgery Cover			
26	Well Baby Cover			
27	No Active Line of Treatment Cover			

3. Personal Accident Benefits

Sr No.	Name of the Benefit	Event Covered (Illness/Injury)	Sum Insured / Sub-Limit	Other Conditions (Provide Details)
1	Accidental Death Benefit		Common Death or Disability Sum Insured	
2	Permanent Total Disability			
3	Permanent Partial Disability			
4	Temporary Total Disability			
5	Child Education Cover			Frequency: _____
6	Disappearance Cover			
7	Loan Protector			
8	Outstanding Bills Protection Benefit			
9	Convenient Travel Option			
10	Modification of Vehicle/Home			
11	Chauffer Benefit		Rs ____ per day	Max. no. of days____

4. Personal Accident Benefits (Cover Options)

Sr No.	Name of the Benefit	Event Covered (Illness/Injury)	Sum Insured / Sub-Limit	Other Conditions (Provide Details)
1	Personal Accidental (Common Carrier)			
2	Additional Permanent Total Disability			
3	Additional Temporary Total Disability			

5. Critical Illness Benefits

Sr No.	Name of the Benefit	Event Covered (Illness/Injury)	Sum Insured / Sub-Limit	Other Conditions (Provide Details)
1	Critical Illness Benefit			Waiting Period: _____ Survival Period: _____

6. Critical Illness Benefits (Cover Options)

Sr No.	Name of the Benefit	Event Covered (Illness/Injury)	Sum Insured / Sub-Limit	Other Conditions (Provide Details)
1	Critical Illness Benefit Waiting Period			No. of days:____
2	Survival Period for Critical Illness			No. of days:____

7. Domestic Travel Benefits

Sr No.	Name of the Cover Option	Event Covered (Illness/Injury)	Sum Insured / Sub-Limit	Other Conditions (Provide Details)
1	Trip Delay			Min. no. of Hours: ____ Deductible Hours: ____
2	Trip Cancellation & Interruption			Min no. of Hours: _____
3	Trip Curtailment			
4	Delay of Checked-in Baggage			Min. no. of Hours: ____ Deductible Hours: ____
5	Loss of Checked-in Baggage			
6	Loss of Baggage and Personal Effects			
7	Personal Liability			
8	Financial Emergency Cash			
9	Kidnap / Hijack / Extortion Coverage			Min. no. of Hours: ____
10	Carrier Cancellation			Max. no. of Hours: _____
11	Cancellation of Carrier by Insured Person			Deductible Amount: ____
12	Denied Boarding - Carrier			Max. no. of Hours: _____
13	Missed Carrier			Deductible Amount: _____
14	Missed Event			Deductible Amount: _____
15	Missed Connection			Min. no. of Hours: ____
16	Fare Lock			Max. no. of Hours: _____
17	Fare Dip			Max. no. of Hours: _____
18	Electronic Equipment Cover			Deductible Amount: ____
19	Denied Hotel Accommodation			
20	Emergency Hotel Requirement			
21	Home Insurance Cover			
22	Fire and Allied Perils (Home Building & Contents)			
23	Travel with Pet Cover			

8. OPD and Wellness Benefits

Sr No.	Name of the Benefit	Event Covered (Illness/Injury)	Sum Insured / Sub-Limit	Other Conditions (Provide Details)
1	Out-Patient Treatment Cover (OPD)			

2	Dental Cover			
3	Vision Expenses Cover			
4	LASIK			
5	Preventive Health Check-up			
6	Prescribed Diagnostics			

9. Special Services Benefits

Sr No.	Name of the Benefit	Event Covered (Illness/Injury)	Sum Insured / Sub-Limit	Other Conditions (Provide Details)
1	Domestic Emergency Evacuation			
2	International Emergency Evacuation			
3	Medical Equipment Cover			

10. Waiting Period

Sr No.	Waiting Periods	Selected Period
1	Initial 30 Days Waiting Period	
2	Specific Illness Waiting Period	
3	Pre-Existing Disease Waiting Period	
4	Maternity Waiting Period	
5	Critical Illness Waiting Period	
6	Critical Illness Survival Period	

Annexure 3:

Sr No	Name of Pet	Identification Mark (Nose print, Tattoo etc)	Age	Gender	Pet Type (Breed, Animal etc)	Coverage Category	Address of the Insured
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