GROUP HEALTH & ACCIDENT CARE 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:** _____

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*): _____

- Nature of Group: Employer/employee OR Non-employer/employee

- Description of the Group: _____

- Nature of Policy: Names basis OR Unnamed basis

- Please state whether all eligible Insured Persons/families of the Group / Association / Institution / Corporate Body are proposed for insurance? Yes _____ No _____
- Please state the total number of Insured Persons to be covered *(including families / dependents wherever covered*): _____

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

- Are your employees/ Insured Persons at present insured under any Personal Accident? 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.

- Name of the Proposer: _____

For unnamed members / Employees:

Coverage Category / Sum Insured Level / Insured Category etc	No of Members / Employees
Category A	
Category B	
Category C	

For Named member / Employees: Fill the Annexure 1
Please attach additional sheets, if space not sufficient to complete details.

IV. BENEFITS:

Category	Nature of Business
Category A	
Category B	
Category C	

Note: *All the benefits can be chosen for the group. 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 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 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. SECTION 41 OF INSURANCE ACT, 1938 (PROHIBITION OF REBATES)

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
1.										
2.										
3.										
4.										
5.										
6.										
7.										
8.										
9.										
10.										
11.										
12.										
13.										
14.										
15.										
16.										
17.										
18.										
19.										
20.										
21.										
22.										
23.										
24.										
25.										
26.										
27.										
28.										
29.										
30.										
31.										
32.										
33.										
34.										
35.										
36.										
37.										
38.										
39.										
40.										

Note: *This list is indicative and details could be modified according to the Nature of Group/ Policy.

Annexure 2:

Please enter “None” for Sum Insured of Cover Benefits not opted for.

S.No.	Name of Benefit	Category A		Category B		Category C	
		Common Sum Insured per Insured Person (INR)	Additional Conditions	Common Sum Insured per Insured Person (INR)	Additional Conditions	Common Sum Insured per Insured Person (INR)	Additional Conditions
1	Accidental Death Benefit						
2	Permanent Total Disability						
3	Permanent Partial Disability						
4	Temporary Total Disability						

S.No.	Name of Benefit	Category A			Category B			Category C		
		Sum Insured per Insured Person (INR)	Additional Conditions		Sum Insured per Insured Person (INR)	Additional Conditions		Sum Insured per Insured Person (INR)	Additional Conditions	
5	Medical Expense Reimbursement									
6	Loan Protector									
7	OPD Treatment									
8	Child Education Cover									
9	Hospital Fixed Allowance									
10	Disappearance Cover									
11	Repatriation of Mortal Remains									
12	Mobility Cover									
13	Funeral Expense									
14	Compassionate Visit									
15	Compassionate Visit Stay									
16	Convenient Travel option									
17	Outstanding Bills Protection Benefit									
18	Ambulance and Emergency Transportation Cover									
19	Modification of vehicle/home									
20	Evacuation (Medical & Catastrophe)									
21	Physiotherapy									
22	Chauffeur Benefit									
23	Emergency Hotel Requirement									
24	Hospital Daily Allowance		Min Days	Max Days		Min Days	Max Days		Min Days	Max Days
25	EMI Protection									
26	Missed Bill Payment									
27	Personal Liability									
28	Loss of Baggage and Personal Effects									

S.No.	Name of Benefit	Category A		Category B		Category C	
		Sum Insured per Insured Person (INR)	Additional Conditions	Sum Insured per Insured Person (INR)	Additional Conditions	Sum Insured per Insured Person (INR)	Additional Conditions
29	Electronic Equipment Cover		Depreciation as per special condition 2				
30	Hardship Allowance						
31	Kidnap / Hijack / Extortion Coverage		Min Hours		Min Hours		Min Hours
32	Loss of Job		Min Days		Min Days		Min Days
33	Critical Illness Fixed Benefit						

Sr. No.	Cover Options	Category A		Category B		Category C	
		Sum Insured per Insured Person (INR)	Additional Conditions	Sum Insured per Insured Person (INR)	Additional Conditions	Sum Insured per Insured Person (INR)	Additional Conditions
A	Personal Accident (Common Carrier)						
B	Additional Permanent Total Disability						
C	Additional Temporary Total Disability						

Sr No.	Waiting Periods	Remarks
1	Pre-Existing Disease Waiting Period	
2	Initial Waiting Period for Hospitalization	
3	Specific Illness Waiting period	
4	Critical Illness Waiting Period	
5	Critical Illness Survival Period	

Global Coverage applicable: - Yes/No
Currency used for Global coverage: _____

Critical Illness Benefit (if applicable)

Coverage Category / Sum Insured Level / Insured Category etc	Critical Illness Group Opted:
Category A	
Category B	
Category C	

S.NO.	CRITICAL ILLNESS	GROUP			
		15 CI's	18 CI's	25 CI's	36 CI's
1	Cancer of Specified Severity	√	√	√	√
2	Kidney Failure Requiring Regular Dialysis	√	√	√	√
3	Multiple Sclerosis with Persisting Symptoms	√	√	√	√
4	Major Organ / Bone Marrow Transplant	√	√	√	√
5	Open Heart Replacement or Repair of Heart Valves	√	√	√	√
6	Open Chest CABG	√	√	√	√
7	Permanent Paralysis of Limbs	√	√	√	√
8	Myocardial Infarction (First Heart Attack – of Specific Severity)	√	√	√	√
9	Stroke Resulting in Permanent Symptoms	√	√	√	√
10	Benign Brain Tumor	√	√	√	√
11	Parkinson's Disease	√	√	√	√
12	Coma of Specified Severity	√	√	√	√
13	End Stage Liver Failure	√	√	√	√
14	Alzheimer's Disease	√	√	√	√
15	Aorta Graft Surgery	√	√	√	√
16	Major Burns	×	√	√	√
17	Loss of Hearing (Deafness)	×	√	√	√
18	Loss of Speech	×	√	√	√
19	Loss of Vision (Blindness)	×	×	√	√
20	Motor Neurone Disease with Permanent Symptoms	×	×	√	√
21	Loss of Limbs	×	×	√	√
22	Aplastic Anaemia	×	×	√	√
23	End Stage Lung Failure	×	×	√	√
24	Primary (Idiopathic) Pulmonary Hypertension	×	×	√	√
25	Bacterial Meningitis	×	×	√	√
26	Apallic Syndrome or Persistent Vegetative State (PVS)	×	×	×	√
27	Coronary Angioplasty (PTCA)[1]	×	×	×	√
28	Encephalitis	×	×	×	√
29	Fulminant Hepatitis	×	×	×	√
30	Chronic Relapsing Pancreatitis	×	×	×	√
31	Major Head Trauma	×	×	×	√
32	Medullary Cystic Disease	×	×	×	√
33	Muscular Dystrophy	×	×	×	√

S.NO.	CRITICAL ILLNESS	GROUP			
		15 CI's	18 CI's	25 CI's	36 CI's
34	Poliomyelitis	×	×	×	√
35	Systemic Lupus Erythematous	×	×	×	√
36	Brain Surgery	×	×	×	√

Declarations:

Special Conditions:

1. Loss of Job is not covered for any unemployment if it arises as a result of the place of employment or part thereof being temporary closed down for a period not exceeding ___ number of days due to lay off, lockout, strike or any other reason.

2. For Electronic Equipment Cover depreciation grid will follow as below_____