

## Proposal Form For Group Health Insurance Policy

### For Official Use Only

Agent/ Broker Name: \_\_\_\_\_ Marketing Officer: \_\_\_\_\_

Branch Address: \_\_\_\_\_ Marketing Officer: \_\_\_\_\_

Group ID: \_\_\_\_\_ Client ID: \_\_\_\_\_ Phone No. \_\_\_\_\_

### Guidelines For Completion Of The Form

1. Please answer all 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 Insured not only to disclose all material facts but also not to suppress any material facts in response to the questions in the proposal form. If you think any fact is material, please disclose it.
3. The Policy shall become voidable at the option of the Insurer, in the event of any untrue or incorrect statement, misrepresentation, non-description or non-disclosure in any material particular in the proposal form/personal statement, declaration and connected documents or any material information having been withheld by the Proposer or any one acting on his behalf.
4. Kindly contact the Company's Offices or Agents for any doubts or clarifications on the proposal form.

**NOTE:** The liability of the Company does not commence until this proposal has been accepted by the Company and premium has been paid.

**SCOPE OF COVER:** This Policy covers reimbursement of hospitalisation expenses incurred for diseases contracted or injuries sustained in India. Medical expenses upto 30 days for Pre-hospitalisation and upto 60 days for post-hospitalisation are also admissible.

The sum insured under this Policy for a particular Insured person and/or all the dependant members of his/her family shall be the aggregate total sum insured available to the Insured person and each dependant member of his/her family, as would be set out in the Policy.

**SIGNIFICANT EXCLUSIONS:** Pre Existing Diseases, Diseases contracted During First 30 Days, Cost of Spectacles / Contact Lenses, Dental Treatment, AIDS, Pregnancy and certain specified diseases during first year of the Policy. For a detailed set of exclusions, kindly consult the policy document.

**EXTENSIONS:** In addition certain optional extensions are available, the details of which, are provided in the relevant section of this proposal form.

**NOTE:** The foregoing is only an indication of the cover offered. For details, please refer to the Policy.

### CLIENT INFORMATION

Proposer's Name: ANJUMAN ISLAM JANJIRA DEGREE

COLLEGE OF SCIENCE

Proposer's Mailing Address: LOKMANYA TILAK ROAD BAZAR

PETH MURUD JANJIRA DIST RAIGAD

City / Town / Village MURUD JANJIRA

State MAHARASHTRA Pin Code 402401

Contact No. 7038601376 Mobile \_\_\_\_\_

E-Mail Address aijcollege@gmail.com

Proposer's trade or business: \_\_\_\_\_

Particulars of Work: \_\_\_\_\_

Type of Proposer: ☐ Individual ☐ Partnership firm ☐ Company ☐ Govt. ☐ Others: \_\_\_\_\_

Constitution of Business: ☐ Non Resident Entity ☐ Foreign company registered in India ☐ Foreign LLP

☐ Government Department ☐ Hindu Undivided Family ☐ LLP Partnership ☐ Public Ltd Co

☐ Local Authorities ☐ Partnership ☐ Private Limited Company ☐ Proprietorship

☒ Others, Please Specify: COLLEGE

Customer Type: ☐ General ☐ EOU/STP/EHTP ☐ Government ☐ Overseas ☐ Related parties ☐ SEZ

☐ Others, Please Specify: \_\_\_\_\_

Annual Income: \_\_\_\_\_ Do you file income tax return? ☐ Yes ☐ No

Do you own a bank account? ☐ Yes ☐ No

Country INDIA PAN Number: \_\_\_\_\_

Paid-up capital of the firm (in ₹ million) \_\_\_\_\_

Business Sector: ☐ Urban ☐ Rural \*Registered GST: ☐ Yes ☐ No (One Policy One Invoice)

If Yes, then please provide GSTIN: \_\_\_\_\_

Address (Registered under GST): \_\_\_\_\_

One Policy Multiple Invoice: ☐ Yes ☐ No [If yes, it can be taken as an Annexure to Proposal Form as detailed below]

If Yes, then please provide: \_\_\_\_\_

Are you or any of the proposed applicants/beneficial owner a PEP\* or a close relative of a PEP\*? ☐ Yes ☐ No

If yes, please give details: \_\_\_\_\_

\*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.

Note: In all above cases, complete address of the customer is required to be taken.

State-wise GSTIN	Address Registered under respective GSTIN

### Contact Details

Proposer's Name: \_\_\_\_\_

Proposer's Mailing Address: \_\_\_\_\_

City / Town / Village \_\_\_\_\_

State \_\_\_\_\_ Pin Code \_\_\_\_\_

Contact No. \_\_\_\_\_ Mobile \_\_\_\_\_

E-Mail Address \_\_\_\_\_

### Risk Details

of person to be insured in the following format.

Period of Insurance: \_\_\_\_\_ To Midnight \_\_\_\_\_

Number of Persons to be Insured \_\_\_\_\_

Sr. No.	Name of the employee/ self and dependent	Relationship with the employee/ self	Date of Birth	Age	Gender	Sum Insured (₹.)	Specify existing diseases, if any
1			DD/MM/YYYY		M/F		
2			DD/MM/YYYY		M/F		
3			DD/MM/YYYY		M/F		
4			DD/MM/YYYY		M/F		

Note:

1) Please provided an additional sheet if space is not sufficient to complete details.

2) Names of the dependents should be mentioned immediately below the name of each employee.

Do all the members proposed to be insured form part of One Group or Association or Corporate body? ☐ Yes ☐ No Kindly provide the particulars for the past 3 policy periods or less period for which policy availed, in the following format.

Period of Insurance		Name & Address of the Insurer	Policy Number	Total Premium (₹)	Total Amount of claims (₹) (Paid + Outstanding)
From Date	To Date				

UIN: ICIHLGP24018V052324

CIN : L67200MH2000PLC129408



1) If you want to avail of extension of the policy by payment of additional premium, please specify

- 1 Maternity Benefits ☐ Yes ☐ No  
2 Pre-existing Diseases ☐ Yes ☐ No  
3 Reimbursement of Cost of Health Check-Up ☐ Yes ☐ No

Note: The Reimbursement of Cost of Health Check-Up Extension is only available after 4 consecutive claims free years of policy availed

2) If you want to avail of exclusion of coverage under the policy with consequent reduction of premium, please specify:

- 1 Domiciliary Hospitalisation ☐ Yes ☐ No  
2 Pre & Post Hospitalisation Cover ☐ Yes ☐ No

Any Additional information relevant to the policy applied for

Note: Kindly refer the annexure for the list of add-ons. Please use additional sheets if space is not sufficient to complete details.

### Payment Information Mode Of Payment

☐ Cheque ☐ Demand Draft ☐ Demand Draft No. ☐ cash ☐ Credit Card

Drawn On: ICICI LOMBARD GIC LTD Dated 21/10/2024

Bank Account No. 000405007307 Amount in Figures: 72926

Amount in Words: Seven Thousand Two Hundred Ninety Two only

### Declaration By Proposer

I/We, the undersigned hereby declare that the above statements and particulars are true, accurate and complete and I/We declare and agree that this declaration and the answers given above shall be held to be promissory and shall be the basis of the contract between me/us and the Company. I/We agree that the Company may exchange, share or part with any information to or with other ICICI Group Companies or any other person in connection with the Proposal, as may be determined by the Company and shall not hold the Company liable for such use/application.

I/We, hereby declare, on my behalf and on the behalf of all the 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 are authorized to propose on behalf of these other persons.

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 the full receipt of the premium chargeable

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 of the company.

I/We declare and consent to the company seeking medical information from any doctor or from a hospital who at anytime has attended on the life to be insured/proposer 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 assured/proposer has been made for the purpose of underwriting the proposal and/or claim settlement.

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.

I hereby give my consent to the Company to verify and obtain my identity/address proof as well as the identity/address proof of the insured through Central KYC Registry or UIDAI or through any other modes for the purpose of undertaking KYC

I/We hereby agree and ensure to maintain details of all the beneficiaries covered under the policy and shall share the same with Company as and when required

Place: Murud Janjira Date: 21/10/2024

Name: Dr. Sajid F. Sheikh

Designation: Incharge Principal

Company Seal:



Signature and Stamp  
U/C PRINCIPAL  
Anjuman Islam Janjira  
Degree College of Science  
Janjira Murud, Dist. Raigad

### Statutory Warning

PROHIBITION OF REBATES. (Under Section 41 of Insurance Act 1938)

- 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.
- 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

Referred by :

Agent Name :

Agent Code :

Sector : ☐ Urban ☐ Rural ☐ Social

For Official Use Only  
Vertical Information

Agent Name :

Received date & time by MO. Date : 21/10/2024

Marketing Officer :

Time : 11:11 AM

UIN: ICIHLP24018V052324

CIN: L67200MH2000PLC129408

### Terms and Conditions for Payments through RTGS/NEFT

1. The details provided by the Customers in the Mandate Form shall be considered as final and ICICI Lombard General Insurance Company Ltd. shall not be responsible for cross verification of any of the details provided therein.
2. The RTGS/ NEFT facility shall be effective for the respective Customer(s) within 15 days of the receipt of the Mandate Form by ICICI Lombard General Insurance Company Ltd. and/ or within such period as may be reasonably required by ICICI Lombard General Insurance Company Ltd. to activate the RTGS/NEFT facility.
3. The Customer agrees that under the RTGS/ NEFT facility, there may be a risk of non-payment in the Account of Customer on the day of the credit of Payments due to change in the applicable regulations pertaining to RTGS/ NEFT facility or due to any other reasons without any fault/inaction/failure on part of ICICI Lombard General Insurance Company or any factor beyond the control of ICICI Lombard General Insurance Company Limited.
4. The Customer agrees to indemnify, without delay or demur, ICICI Lombard General Insurance Company Ltd. and its agents and keep ICICI Lombard General Insurance Company Ltd. and its agent indemnified harmless at all times from and against any and all claims, damages, losses, costs, and expenses (including attorney's fees) which ICICI Lombard General Insurance Company Ltd. may suffer or incur, directly or indirectly, arising from or in connection with, amongst other things, either of the aforesaid reasons stated in above clauses.
5. The Customer agrees that transaction(s) through RTGS/ NEFT facility may attract inward RTGS/ NEFT charges, which if levied by the Customer's bank, shall be borne by the Customer
6. ICICI Lombard has the absolute discretion to amend or supplement any Terms and Conditions stated herein at any time and will endeavour to give prior notice of Ten days for such changes wherever feasible for the terms and conditions to be applicable. By using the new services, or at the completion of such period, whichever is earlier, the Customer shall be deemed to have accepted the changed terms and conditions.
7. Submission of documents or bank details or any other information does not in any way, shape or form, imply or express or suggest admission of liability by the company.
8. Notices under these terms and conditions may be given in writing by delivering them by hand or e-mail or on ICICI Lombard General Insurance Company Ltd. Website [www.icicilombard.com](http://www.icicilombard.com) or by sending them by post to the last address of the Customer.
9. These terms and conditions will be governed by the laws of India and any legal action or proceedings arising out of these Terms and Conditions shall be initiated in the courts or tribunals at Mumbai in India.
10. I/ We further undertake to refund any excess amount whether demanded by ICICI Lombard General Insurance Company Ltd. or not, which has been credited in excess to my account at any time due to any reason within 7 days of such receipt of such communication from ICICI Lombard of such excess credit or such information of excess credit coming to the knowledge of the Customer through any other source.
11. I/ We agree that my/our claim payment will be credited from the date ICICI Lombard General Insurance Company Ltd. gets confirmation from its bankers. This facility will continue unless it is revoked by any party and any issuance of relevant credit instruction from ICICI Lombard General Insurance Company Ltd. to its bankers will be valid till such instruction is complete irrespective of the fact that the notice period has expired provided such a credit request has been made by ICICI Lombard General Insurance Company Ltd. before the expiry of the notice period of the Customer.
12. Please attach a blank cancelled cheque or photocopy of a cheque for verification of the particulars provided in this regard.



*A. Ishtiaq*  
**I/C PRINCIPAL**  
Signature and Stamp of Customer  
Anjuman Islam Janjira  
Degree College of Science  
Janjira Murud, Dist. Raigad



**KNOW YOUR CLIENT (KYC) APPLICATION FORM**  
**For Non-Individuals (Please fill this form in ENGLISH and in BLOCK LETTERS.)**

**A. IDENTITY DETAILS**

1. Name of the Applicant: Anjuman Islam Tanjira Degree College of Science <sup>1. N</sup>
2. Date of incorporation: \_\_\_\_\_ (dd/mm/yyyy)
3. Place of incorporation: Murud Tanjira
4. a. PAN: AAB7A 71 96C
- b. Registration No. (E.g. CIN): \_\_\_\_\_
6. Status (please tick any one):
- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Private Limited Co.   | <input type="checkbox"/> Public Ltd. Co.   | <input type="checkbox"/> Unincorporated Association or Body of Individuals |
| <input type="checkbox"/> Partnership/LLP   | <input type="checkbox"/> Trust/ Foundation | <input type="checkbox"/> Government  |
| <input type="checkbox"/> NGO/NPO (If yes, obtain DARPAN Portal Registration number.....) |  |  |
| <input checked="" type="checkbox"/> Others (please specify) <u>College</u>               |  |  |
7. Nature of Business: \_\_\_\_\_
8. \* Documents submitted: \_\_\_\_\_

\* For identity proof, please refer the list of documents at Annexure A

**B. ADDRESS DETAILS**

1. Address for correspondence/principal place of business:
- Lokmanya Tilak Road, Bazar peth, Murud Tanjira <sup>Dist. Raigad</sup>
- City/town/village Murud Tanjira Pin Code: 402401 State: Maharashtra
- Country: India
2. Contact Details: Tel. (Off.) \_\_\_\_\_ Tel. (Res.) \_\_\_\_\_ Mobile \_\_\_\_\_
- No.: 7038601376 Fax: \_\_\_\_\_ Email id: aijcollege@gmail.com
3. Specify the \*proof of address submitted for correspondence address:
- \_\_\_\_\_ (For address proof, please refer the list at Annexure A)
4. Registered Address (if different from above): \_\_\_\_\_
- City/town/village: \_\_\_\_\_ Pin Code: \_\_\_\_\_

State: \_\_\_\_\_ Country: \_\_\_\_\_

**C. OTHER DETAILS (Authorized Signatory)**

1. Name:
2. Current residential address:
3. Any officially valid document containing photographs of Authorized Signatory:

---

---

---

**4. PLEASE TICK, IF APPLICABLE:**

- ☐ \*\*Politically Exposed Person (PEP) ☒ Family member/ Close relatives/Associates of PEPs  
☐ No

If Yes, (Explain Nature of relationship and position hold of PEP) \_\_\_\_\_

**D. Details of Beneficial Owner\***

Mention the details of individual persons who has/have the Beneficial Ownership in the captioned entity:

Sr. no	Particular						
	Full name	Date of birth	Nationality	Address	% share holding	PAN	**Politically Exposed Person(PED) Declaration
							<input type="checkbox"/> PEP <input checked="" type="checkbox"/> Family member/ Close relatives/Associates to PEP <input type="checkbox"/> No
							<input type="checkbox"/> PEP <input checked="" type="checkbox"/> Family member/ Close relatives/Associates to PEP <input type="checkbox"/> No
							<input type="checkbox"/> PEP <input checked="" type="checkbox"/> Family member/ Close relatives/Associates to PEP <input type="checkbox"/> No
							<input type="checkbox"/> PEP <input checked="" type="checkbox"/> Family member/ Close relatives/Associates to PEP <input type="checkbox"/> No

## DECLARATION

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.

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.

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

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.

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.

Dr. Sajid F. Sheikh

Name & Signature of the Authorised Signatory

Date: 21/10/2024 (dd/mm/yyyy)

*1/8/2024*  
**I/C PRINCIPAL**  
Anjuman Islam Janjira  
Degree College of Science  
Janjira Murud, Dist. Raigad



### Important note:-

(\*) The beneficial owner shall be determined as follows:

- where the client is a company, the beneficial owner is the natural person(s), who, whether acting alone or together, or through one or more juridical person, has a controlling ownership interest (more than ten percent of shares or capital or profits of the company) or who exercises control through other means
- where the client is a partnership firm, the beneficial owner is the natural person(s), who, whether acting alone or together, or through one or more juridical person, has ownership of/entitlement to more than ten percent of capital or profits of the partnership or who exercises control through other means  
*"Explanation - For the purpose of this clause, "Control" shall include the right to control the management or policy decision;"*
- where the client is an unincorporated association or body of individuals, the beneficial owner is the natural person(s), who, whether acting alone or together, or through one or more juridical person, has ownership of or entitlement to more than fifteen percent of the property or capital or profits of such association or body of individuals
- where the client is a trust, the identification of beneficial owner(s) shall include identification of the author of the trust, the trustee, the beneficiaries with ten percent or more interest in the trust and any other natural person exercising ultimate effective control over the trust through a chain of control or ownership



# POLICY SET UP QUESTIONNAIRE

Policy Name*:-	Institution Name
Policy No*:-	
MO Name & EMP ID*:-	99915

## I (a) Payment Matrix:-

1	In case of Reimbursement claim, payment in Employee /Corporate Name(Payee Name)*:-	Anjuman Islam Janjira Degree College of Science, Murud Janjira
2	Mode Of Payment* : Cheque /EFT:-	EFT UTR No. MAHBH24295353452
3	Frequency of Payment: Daily/Weekly/Monthly	Daily

\*\*If Payment is to be made to the member, ONLY Cheque will be issued in the Name of the Self member for Self covered policies and in the name of the proposer for self not covered policies.

4. If the payment mode is Cheque, please furnish following details:-If the HR does not want any mails to be sent to HR, then the RM may not fill the details but in case if CF is applicable in Policy then the HR Details are mandatory as we have a separate tab to enter the details of the HR (Name, Email ID and phone No)

i)	Cheque Dispatch Address with pin code & Contact Person as per Policy or any other Address with pin code*	This is for refund purpose. So the college has to decide whether the refund amount will be credited into their account and they will give to students or they want the insurance companies o directly pay ot to the students. So if college, then college details and if students then they have to give students details.
ii)	HR Name/ Broker Name*	Regional Manager Name
iii)	Contact No:- *	
iv)	Email ID:- *	

\*\* In case a payment needs to be dispatched to ICICI Lombard Branch Office then please provide mail approval from NSM/VP and U/W Head.

5. If payment mode is Electronic Fund Transfer (EFT), please furnish following details:

i)	Bank Name:- *	Either student/college abnk details for refund. Totally depends on college.
ii)	Account Number:- *	NA
iii)	Branch Name:- *	NA
iv)	IFSC Code:- *	NA
v)	Cancelled Cheque copy:- Y/N*	NA
vi)	PAN copy:- Y/N*	NA
vii)	Mandate form received:- Y/N*	NA
Viii)	HR Name*	NA
ix)	Contact No.:- *	NA
x)	Email Id*:	NA

ICICI LOMBARD HEALTH CARE HEALTH ENROLLMENT TEAM



# POLICY SET UP QUESTIONNAIRE

## II (a) Network Booklets Matrix:-

1	Do you Require Network Booklets(Y/N) *:-	NA
---	--	----

\*\*If yes, please provide NSM/VP and U/W Head Approval.

## II (b) Physical Card Dispatch details - If mentioned in policy copy:

1	Please Provide Cards Dispatch address as Per policy or any other address with pin code	If more than 500 lives physical cards will be sent. So the college address
2	Any other details for card printing:-	NA

## III (a) Communication Matrix for Query/Rejection Letters:-

1	Form of Communication: Soft Copy only/Physical Document only/Both/Not Required	SOFT COPY
2	If Physical Documents*: Recipient Name, Contact Number & Recipients complete Postal Address with pin code	NA

3. If Soft Copy\*: E-Mail IDs & Mobile No's (Along with the concerned who should be kept in Loop).

Recipients	Email id	Mobile no
Corp Hr	aijcollege@gmail.com	7038601376
Sub Hr	Institution Mail ID	College id
Broker	Broker Mail ID	
RM	ICICI	

(b) Communication Grid\* (kindly select the relevant event to be triggered) if required. If not selected, same will be ignored.

Claim Type	Communication Events	Communication Recipients									
		Insured		Corporate HR		Sub HR		Broker		RM	
		Email	SMS	Email	SMS	Email	SMS	Email	SMS	Email	SMS
Cashless	Inward Generation	N	Y	N	N	N	N	Y	Y	Y	N
	AI Registration	N	Y	N	N	N	N	Y	Y	Y	N
	AI Approval	N	Y	N	N	N	N	Y	Y	Y	N
	AI Query	N	Y	N	N	N	N	Y	Y	Y	N
	AI Rejection	N	Y	N	N	N	N	Y	Y	Y	N
	AI Fax sent	N	Y	N	N	N	N	Y	Y	Y	N
Reimbursement	Inward Generation	N	Y	N	N	N	N	Y	Y	Y	N
	CL Registration	N	Y	N	N	N	N	Y	Y	Y	N
	CL Approval	N	Y	N	N	N	N	Y	Y	Y	N
	CL Query	N	Y	N	N	N	N	Y	Y	Y	N
	CL Rejection	N	Y	N	N	N	N	Y	Y	Y	N
	Payment	N	Y	N	N	N	N	Y	Y	Y	N
	Cheque Dispatch	N	Y	N	N	N	N	Y	Y	Y	N

ICICI LOMBARD HEALTH CARE HEALTH ENROLLMENT TEAM

**I/C PRINCIPAL**

Anjuman Islam Janjira  
Degree College of Science  
Janjira Murud, Dist. Raigad



### Mandate Letter Guidelines.


We hereby declare that we **Integrated Risk Insurance Brokers Limited** have been exclusively mandated to procure the insurance coverage with regard to Group Health Insurance, Group Personal Accident & all other GI Products name for ICICI LOMBARD GIC LTD for **COB VERTICAL** in accordance with the IRDA (Insurance Brokers) Regulations, 2002.

Thanks & Regards

**Name of Institution:- Anjuman Islam Janjira Degree College of Science, Murud Janjira, Dist. Raigad**

---



  
**I/C PRINCIPAL**  
Anjuman Islam Janjira  
Degree College of Science  
Janjira Murud, Dist. Raigad