

	URN	No.	:	PF/	40	15/	UC
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Proposal Form No.:\_\_\_\_\_

# **Proposal Form For Group Health Insurance Policy**

For Official Use Only  Agent/ Broker Name:	Marketing Officer:
	Mandatina Office
Branch Address Client ID	Marketing Officer:Phone No.
droup ib Client ib	
Guidelines For Completion Of The Form	
1. Please answer all questions fully and correctly. Where any question does not apply, please n	nention clearly that the same is not applicable
<ol> <li>Insurance is a contract of Utmost Good Faith requiring the Insured not only to disclose all mare response to the questions in the proposal form. If you think any fact is material, please disclos.</li> <li>The Policy shall become voidable at the option of the Insurer, in the event of any untrue or in or non-disclosure in any material particular in the proposal form/personal statement, described to the contract of the Insurer.</li> </ol>	nterial facts but also not to suppress any material facts in use it.  ncorrect statement, misrepresentation, non-description
information having been withheld by the Proposer or any one acting on his behalf.	reclaration and connected documents of any material
4. Kindly contact the Company's Offices or Agents for any doubts or clarifications on the propo	sal form.
$\textbf{NOTE:} \ The \ liability \ of the \ Company \ does \ not \ commence \ until \ this \ proposal \ has \ been \ accepted \ begin{picture}(100,00) \put(0,0){\ (0,0) \ ($	by the Company and premium has been paid.
<b>SCOPE OF COVER:</b> This Policy covers reimbursement of hospitalisation expenses incurred Medical expenses upto 30 days for Pre-hospitalisation and upto 60 days for post - hospitalisation	tion are also admissible.
The sum insured under this Policy for a particular Insured person and/or all the dependant men insured available to the Insured person and each dependant member of his/her family, as woul	, , , , , ,
SIGNIFICANT EXCLUSIONS: Pre Existing Diseases, Diseases contracted During First 30 Days	
AIDS, Pregnancy and certain specified diseases during first year of the Policy. For a detailed set	•
$\textbf{EXTENSIONS:} \ In \ addition \ certain \ optional \ extensions \ are \ available, the \ details \ of \ which, \ are \ property \ and \ property \ are \ property \ and \ property \ are \ property \ are \ property \ are \ property \ and \ property \ are \ property \ property \ property \ are \ property \ pro$	
NOTE: The foregoing is only an indication of the cover offered. For details, please refer to the Po	licy.
CLIENT INFORMATION	
Proposer's Name:	
First Name Middle Name	Last Name
Proposer's Mailing Address:	
City / Town / Village	
State	
	Mobile
E-Mail Address	
Proposer's trade or business:	
Particulars of Work:	
Type of Proposer: Individual Partnership firm Company Govt. Constitution of Business: Non Resident Entity Foreign company re	
	amily LLP Partnership Public Ltd Co
	e Limited Company Proprietorship
Others, Please Specify:	
Customer Type: General EOU/STP/EHTP Government  Others, Please Specify:	Overseas Related parties SEZ
Annual Income:	Do you file income tax return? Yes No
Do you own a bank account? Yes No	
	PAN Number:

Paid-up capital of t	he firm (in₹million)						
Business Sector:	Urban Rural	*Registered GS	T: Yes I	No (One	Policy O	ne Invoice)	
If Yes, then please p	orovide GSTIN:						
Address (Registere	d under GST):						
One Policy Multiple	Invoice: Yes N	No [If yes, it can be	taken as an Anı	nexure t	o Propos	al Form as detai	iled below]
If Yes, then please p	provide:						
Are you or any of th	ne proposed applicant	ts/beneficial owne	r a PEP* or a clo	se relati	ve of a P	EP*?  Yes	No
If yes, please give o	letails:			J_J_			
	ons (PEPs) are individuals wh povernment/judicial/military		·	-			eads of States/ Governments,
	omplete address of the custo			,			,
Class	CCTINI		Address Dos	ictored	underre	spective GSTIN	
State-wi	se GSTIN		Address neg	jistered	under res	spective do fin	
Contact Details							
Proposer's Name:							
1 1 1 1 1		First Name	Middle N	ame		Last Name	
Proposer's Mailing	Address:			JJ_ 	J 		
	Address.			J_J_ 			
City / Town / Village				J_J_ 			
State				))_ 		Pin Code	
				1 1			
					obile		
Contact No.				] ] ] 	obile		
				]м	obile		
Contact No.	of person to be ins	ured in the following	ng format.	] м	obile		
Contact No E-Mail Address			ng format.				
Contact No  E-Mail Address  Risk Details							
Contact No E-Mail Address Risk Details Period of Insurance Number of Persons  Sr. Name of the	to be Insured	To Midni Relationship				Sum Insured	Specify existing
Contact No E-Mail Address Risk Details Period of Insurance Number of Persons	to be Insured	Relationship with the	ght DDM	M Y	Y		
Contact No E-Mail Address Risk Details Period of Insurance Number of Persons  Sr. Name of the	to be Insured	To Midni Relationship	ght DDM	M Y	Y	Sum Insured	Specify existing
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Contact No E-Mail Address  Risk Details Period of Insurance Number of Persons  Sr. Name of the self and details  1    2    3   4	to be Insured	Relationship with the	Date of Birth  DD/MM/YYYY  DD/MM/YYYY	M Y	Gender  M/F  M/F	Sum Insured	Specify existing
Contact No E-Mail Address  Risk Details Period of Insurance Number of Persons  Sr. Name of the self and details  1	to be Insured  ne employee/ ependent	Relationship with the employee/ self	Date of Birth  DD/MM/YYYY  DD/MM/YYYY  DD/MM/YYYY  DD/MM/YYYY  details.	Age	Gender  M/F  M/F  M/F	Sum Insured	Specify existing
Contact No.  E-Mail Address  Period of Insurance  Number of Persons  Sr. Name of th No. self and de  1 2 3 4  Note: 1) Please provided an ac 2) Names of the depende	to be Insured  ne employee/ ependent	Relationship with the employee/ self	Date of Birth  DD/MM/YYYY  DD/MM/YYYY  DD/MM/YYYY  DD/MM/YYYY  details.  ame of each employed	Age Age	Gender  M/F  M/F  M/F	Sum Insured (₹.)	Specify existing
Contact No.  E-Mail Address  Period of Insurance  Number of Persons  Sr. Name of the self and desertion of the self and de	to be Insured  the employee/ ependent  Iditional sheet if space is no ents should be mentioned in	Relationship with the employee/ self	Date of Birth  DD/MM/YYYY  DD/MM/YYYY  DD/MM/YYYY  DD/MM/YYYY  details.  ame of each employed ciation or Corporate I	Age Age	Gender  M/F  M/F  M/F	Sum Insured (₹.)	Specify existing diseases, if any
Contact No  E-Mail Address  Risk Details  Period of Insurance  Number of Persons  Sr. Name of the self and desertion of the dependence of the	to be Insured  the employee/ ependent  Iditional sheet if space is no ents should be mentioned in osed to be insured form pareriod for which policy availed.	Relationship with the employee/ self	Date of Birth  DD/MM/YYYY  DD/MM/YYYY  DD/MM/YYYY  DD/MM/YYYY  details.  ame of each employed ciation or Corporate Bat.	Age  Age	Gender  M/F  M/F  M/F  M/F	Sum Insured (₹.)	Specify existing diseases, if any
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Contact No.  E-Mail Address  Period of Insurance Number of Persons  Sr. Name of the self and desertion of the dependence	to be Insured  the employee/ ependent  Iditional sheet if space is no ents should be mentioned in osed to be insured form pareriod for which policy availe  Insurance  To Date  DDMMYYYYY  DDMMYYYYY  DDMMYYYYYY	Relationship with the employee/ self  t sufficient to complete mediately below the next of One Group or Asso ed, in the following form	Date of Birth  DD/MM/YYYY  DD/MM/YYYY  DD/MM/YYYY  DD/MM/YYYY  details. ame of each employed ciation or Corporate Batt.  dress of	Age  Poody?	Gender  M/F M/F M/F M/F No	Sum Insured (₹.)  Kindly provide the p	Specify existing diseases, if any  articulars for the past  Total Amount of claims (₹)
Contact No.  E-Mail Address  Period of Insurance Number of Persons  Sr. Name of the self and desertion of the self and desertion of the self and desertion of the dependence of the self and desertion of the dependence of the self and of the self and desertion of the dependence of the self and the self an	ditional sheet if space is no ents should be mentioned in osed to be insured form pareriod for which policy availed the state of the should be mentioned in osed to be insured form pareriod for which policy availed the state of the should be mentioned in osed to be insured form pareriod for which policy availed the state of the should be should	Relationship with the employee/ self  t sufficient to complete mediately below the next of One Group or Asso ed, in the following form	Date of Birth  DD/MM/YYYY  DD/MM/YYYY  DD/MM/YYYY  DD/MM/YYYY  details. ame of each employed ciation or Corporate Batt.  dress of	Age  Poody?	Gender  M/F M/F M/F M/F No	Sum Insured (₹.)  Kindly provide the p	Specify existing diseases, if any  articulars for the past  Total Amount of claims (₹)
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1) If you want to avail of extension of the policy by payment of additional p	remium, 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 consecu		
2) If you want to avail of exclusion of coverage under the policy with consec	quent reduction of prem	iium, please specity:
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 no	t sufficient to complete details	) <b>.</b>
Payment Information Mode Of Payment		
Cheque Demand Draft Demand Draft No.	cash Credit C	
Drawn On.	Dat	ed DDMMYYYY
Bank Account No Amount in	Figures:	
Amount in Words:	]	
Declaration By Proposer		
I/We, the undersigned hereby declare that the above statements and particulars are tr	ue, 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	he basis of the contract bet	tween me/us and the Company. I/We
agree that the Company may exchange, share or part with any information to or with with the Proposal, as may/be determined by the Company and shall not hold the Company		
I/We, hereby declare, on my behalf and on the behalf of all the persons proposed to be	insured, that the above sta	atements, 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 authorize	d to propose on behalf of these othe
persons. I understand that the information provided by me will form the basis of the insurance po	olicy, is subject to the Board	d approved underwriting policy of the
$insurance\ company\ and\ that\ the\ policy\ will\ come\ into\ force\ only\ after\ the\ full\ receipt\ of\ the\ policy\ will\ come\ into\ force\ only\ after\ the\ full\ receipt\ of\ the\ policy\ will\ come\ into\ force\ only\ after\ the\ full\ receipt\ of\ the\ policy\ will\ come\ into\ force\ only\ after\ the\ full\ receipt\ of\ the\ policy\ will\ come\ into\ force\ only\ after\ the\ full\ receipt\ of\ the\ policy\ will\ come\ into\ force\ only\ after\ the\ full\ receipt\ of\ the\ policy\ will\ come\ into\ force\ only\ after\ the\ full\ receipt\ of\ the\ policy\ will\ come\ into\ force\ only\ after\ the\ full\ receipt\ of\ the\ policy\ will\ come\ into\ force\ only\ after\ the\ policy\ of\ the\ policy\ on\ policy\ $	he premium chargeable	
I/We further declare that I/We will notify in writing any change occurring in the occupa proposal has been submitted but before communication of the risk acceptance of the co		e life to be insured/proposer after the
I/We declare and consent to the company seeking medical information from any doctor	r or from a hospital who at a	
insured/proposer or from any past or present employer concerning anything whassured/proposer and seeking information from any insurance company to which are		
been made for the purpose of underwriting the proposal and/or claim settlement.	r application for insurance	; off the life to assured/proposer has
I/We authorize the company to share information pertaining to my proposal incl		s for the sole purpose of proposa
underwriting and/or claims settlement and with any Governmental and/or Regulatory / I hereby give my consent to the Company to verify and obtain my identity/address pro	-	address proof of the insured through
CentralKYCRegistryorUIDAlorthroughanyothermodesforthepurposeofundertakingangles and any other modes for the purpose of undertaking any other modes.	ng KYC	
I/We hereby agree and ensure to maintain details of all the beneficiaries covered unwhen required	der the policy and shall sh	are the same with Company as and
·		
Place: Date: DDM M Y	<u>Y</u>	Client's Signature and Stamp
Name		Stamp
Designation :		
Company Seal :		Authorized Signatory
Statutory Warning		
PROHIBITION OF REBATES. (Under Section 4:		
1. No person shall allow or offer to allow, either directly or indirectly as an inducement		
respect of any kind of risk relating to lives or property, in India, any rebate of the premium shown on the policy, nor shall any person taking out or renewing or cont		
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 lakh rupees
Referred by :	Agent Code :	
Agent Name :	Sector : 🗌 l	Urban 🗌 Rural 🗌 Social
For Official Use Only	,	
Vertical Information		
Agent Name:		
Received date & time by MO. Date: DIDIMIMIYIYIYI	Time: H   H   / M   M	

### **Data Sharing Format For Group Health Policies** Insured Details Name of Insured/Proposer Address of Insured/ Proposer Business of Insured/ Proposer Contact Person at Insured Phone no. and E-mail ID Employer-Employee relationship Yes If No, specify relationship Intermediary Details Name of the Intermediary (Existing & New if applicable) Contact Details including E Mail ID **TPA Details** Name and Address Contact Details Landline: Cell: **Expiring Policy Details** Period of Insurance and Policy Number (Inception Date and Expiry Date) Policy copy with terms/conditions including extensions is to be mandatorily provided by the Proposer Policy Type Base Policy / Top Up policy Premium paid at inception (exclusive of Service Tax) Premium deletion during the year Final Premium collected (exclusive of Service Tax) as on date to be Specified. For how many years policy has been active **Member Details Expiring Year** Basis of Premium Charging -per Family or per Member covered No. of Members at inception **Employee** Dependents Addition during the year Deletion during the year Final no. of Members at expiry (With complete enrollment date) Dependents **Employee** Renewal Year No of Members to be covered **Employee** Dependents (relation to be specified) Please Specify Sum Insured required If Family coverage then no of Families to be covered Family/ Floater Sum Insured Claim Details as on (Date to be specified)under expiring policy Reimbursement Cashless Claims paid as on date Claims outstanding as on date If OPD cover given, then mention OPD claims separately Details of Claims paid under Corporate Buffer Facility as on\_ Claims Paid as on Date Claims Outstanding as on date Total claims paid during the last two policy years immediately preceding the expiring year. Total claims paid during the last three months of two years of policy immediately preceding to the expiring year. Family Details (specify wherever applicable) Family Definition Whether Additional Children Covered Whether Additional Relationships Covered, like brother / sister etc. Any revision required in Family definition under renewal policy - please specify if yes. Corporate Buffer Details required under Renewal Policy Per Family Maximum SI for Corporate Buffer Maximum Number of cases during the Policy period for Corporate Buffer if same is to be capped I/We here by declare, on my behalf and on behalf of all persons proposed to be insured, that the above statements, answers and/or particulars given y me are true and $complete in all \ respects \ to \ the \ best \ of \ my \ knowledge \ and \ that \ l/We \ am/are \ authorized \ to \ propose \ on \ behalf \ of \ these \ persons.$ Date: Place: Signature of the Designated Official of the Insured With Name and Designation Signature of the Intermediary or Agent With Name and

UIN: ICIHLGP24018V052324 CIN: L67200MH2000PLC129408

Designation



URN No.: PF/4015/00 Proposal Form No.:	
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## **NEFT/EFT Mandate Form**

(Payment through EFT Mechanism)

CORPORATE DETAILS								
Group/ Network Name:								
	First Nam	ne	M	ddle Name		Last Na	me	
Address:								
					.     .			
City				Landmar	K			
State								
Pincode:	Pan Card No.:	.**		 				
		·			1 1 1	1 1 1	1 1 1	1 1 1 1
PAN Card Holder's Name:								
ACCOUNT DETAILS								
ACCOUNT DETAILS								
Bank Name:					JJ			
Branch Name:	First Nam	me 	M	iddle Name	1 1 1	Last Na	me 	
Payee Name:								
MICR No.:	IFSC Co	ode:						
Account Type:				 	ر المالية Sull Accoun	it No.:		
Name as per Bank Records:								
Cancel cheque No.**:								
(5)	•••							
(Please attach a blank cancelled che				-				:
If customer name/ account no /IFSC co is mandatory.	ae is not avallar	bie on cancelle	a Cneque tne	n NEF i manac	ate form witi	n Bank Sign &	seal and custor	ner signature
I hereby declare that the particulars of	given above are (	correct and co	mplete. If the	transaction is	delayed or r	not effected a	t all reasons of i	ncomplete or
incorrect information, I would not hold	the user instituti	ion responsible	e.					
								Verified By
Signature & Stamp of the Payee						(Bank Official S	tamp and Authori	•

#### 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 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 P	lease attach a blank car	scallad chaqua	rnhotoconyo	facheaug for	varification of th	a particulare pr	ovided in this regard

Signature and Stamp of Customer

### **Annexure**

Sr. No.	Add-Ons/ Extensions	Options	Details (If any)
1	Cover for Pre-Existing Diseases		
2	Maternity Expenses		
3	Out Patient Department (OPD) Expenses		
4	Cost of Prescribed External Medical Aid		
5	Baby Day One Cover		
6	Critical Illnesses Cover		
7	Travel Expenses for Medical Treatment		
8	Dental Expenses		
9	Cover for Alternate Methods of Treatment		
10	Donor Expenses		
11	Ambulance Charges		
12	Pre and Post Hospitalization		



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