ICICI Lombard
Nibhaye Vaade

URN No. : PF/4015/00

Proposal Form No.: _____

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: IDEAL INSTITUTE OF PHARMACY
(First Name / Middle Name / Last Name)

Proposer's Mailing Address: IDEAL INSTITUTE OF PHARMACY
POSHERI WADA PALGHAR MAHARASHTRA

City / Town / Village POSHERI WADA

State MAHARASHTRA Pin Code 401303

Contact No. 7678002000 Mobile 7977624404 6

E-Mail Address PRINCIPAL@IDEALPHARMACYWADA.COM
principal@idealpharmacywada.com

Proposer's trade or business: EDUCATION

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: EDUCATIONS

Customer Type: ☐ General ☐ EOU/STP/EHTP ☐ Government ☐ Overseas ☐ Related parties ☐ SEZ
☐ Others, Please Specify: EDUCATIONAL INSTITUTE

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

Do you own a bank account? ☑ Yes ☐ No

Country: INDIA PAN Number: AATI3428E

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: DR. SONALI VINOD UPPALWAR
First Name Middle Name Last Name

Proposer's Mailing Address: IDEAL INSTITUTE OF PHARMACY
WADA POSHERI MAHARASHTRA

City / Town / Village POSHERI WADA Pin Code 421303

State MAHARASHTRA Mobile 7972440446

Contact No. 7678002000

E-Mail Address principal@idealpharmacy.edu.co

Risk Details

of person to be insured in the following format.

Period of Insurance: D D M M Y Y Y Y To Midnight D D M M Y Y Y Y

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.
3) 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 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				
D D M M Y Y Y Y	D D M M Y Y Y Y				
D D M M Y Y Y Y	D D M M Y Y Y Y				
D D M M Y Y Y Y	D D M M Y Y Y Y				
D D M M Y Y Y Y	D D M M Y Y Y Y				
D D M M Y Y Y Y	D D M M Y Y Y Y				

) 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

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

) 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

lote: 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. _____ Dated D D M M Y Y Y Y

Bank Account No. _____ Amount in Figures: _____

Amount in Words: _____

Declaration By Proposer

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: Ideal Institute of Pharmacy Date: 28/01/2025

Name Dr. Sonali Vinod Uppalwar

Designation : principal.

Company Seal :

Client's Signature and Stamp

Authorized Signatory

Ideal Institute of Pharmacy
Wada, Palghar

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: _____ Marketing Officer: _____

Received date & time by MO. Date : D D M M Y Y Y Y Time: H H M M

Data Sharing Format For Group Health Policies

Insured Details		
Name of Insured/ Proposer	Ideal Institute of pharmacy	
Address of Insured/ Proposer	Pathesi wada palghar.	
Business of Insured/ Proposer		
Contact Person at Insured	7976244046	
Phone no. and E-mail ID	Principal@idealpharmacywada.com.	
Employer-Employee relationship ☐ Yes ☐ No		
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)	Employee	Dependents
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 s 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 I/We am/are authorized to propose on behalf of these persons.

Date 28/01/25
Place : Ideal Institute of Pharmacy wada,

Signature of the Designated Official of the Insured With Name and Designation

Dr. Sonali Vinod Patil
Principal
Ideal Institute of Pharmacy
Wada, Palghar

Signature of the Intermediary or Agent With Name and Designation

N: ICIHLGP24018V052324

CIN : L67200MH2000PLC129408

ICICI Lombard
Nibhaye Vaade

URN No. : PF/4015/00 Proposal Form No.: _____

NEFT/EFT Mandate Form

(Payment through EFT Mechanism)

CORPORATE DETAILS

Group/ Network Name: _____ (First Name / Middle Name / Last Name)

Address: _____ Landmark _____

City _____

State _____

Pincode: _____ Pan Card No.:** _____

PAN Card Holder's Name: _____

ACCOUNT DETAILS

Bank Name: _____ (First Name / Middle Name / Last Name)

Branch Name: _____

Payee Name: _____

MICR No.: _____ IFSC Code: _____ Full Account No.: _____

Account Type: _____

Name as per Bank Records: _____

Cancel cheque No.**: _____

(Please attach a blank cancelled cheque copy with payee name printed on the cheque and Pan Card Copy)

If customer name/ account no /IFSC code is not available on cancelled Cheque then NEFT mandate form with Bank Sign & seal and customer signature is mandatory.

I hereby declare that the particulars given above are correct and complete. If the transaction is delayed or not effected at all reasons of incomplete or incorrect information, I would not hold the user institution responsible.

Principal
Ideal Institute of Pharmacy
Wada, Palghar

Signature & Stamp of the Payee

Verified By
(Bank Official Stamp and Authorized Signature)

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. Please attach a blank cancelled cheque or photocopy of a cheque for verification of the particulars provided in this regard.

Principal
Ideal Institute of Pharmacy
Wada, Palghar

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		