IndusInd GENERAL INSURANCE
FORMERLY RELIANCE GENERAL INSURANCE

Proposal Form No.: _____
(To be filled in by the office)

INDUSIND MOTOR ACCIDENTAL MEDICAL EXPENSES - PROPOSAL FORM

Note: 1) To be filled and signed by Proposer and all fields are mandatory to be filled. 2) This proposal shall be the basis of contract for policy issuance. 3) Please complete all sections in capitals & tick boxes wherever applicable. 4) Failure to disclose facts material to assessment of the risk or providing misleading information shall render the contract void ab initio 5) Geographical Area of operation: INDIA.

Vehicle Type: ☐ Two-wheeler

FOR OFFICE USE ONLY			
Proposal Date	D D / M M / Y Y Y Y		
Intermediary Name		Code:	
Branch Name		Code:	
Sales Manager Name		Code:	

DETAILS OF VEHICLE TYPE AND USE			
Registration No.		Date of Registration	D D / M M / Y Y Y Y
Year & Month of manufacturing		Engine No./EV Motor Number*	
Chassis No.		EV Battery Serial No.	
Make		Model	
Fuel Type	☐ Petrol ☐ Diesel ☐ Electric ☐ Bi-fuel	Type of Body	
CC/HP/Kwh		Seating capacity including driver	
Where the vehicle being used	☐ Metro Usage ☐ Rural Usage ☐ Semi-Urban Usage ☐ Hilly Terrain ☐ Off Road Usage		

DETAILS OF THE PROPOSER		
Insured Type	☐ Individual ☐ Company	
Insureds Full Name	☐ Mr. ☐ Ms. ☐ Mrs. ☐ M/S. (If Company is selected above)	
	Permanent Address	Correspondence Address (Where vehicle is going to be kept)
Flat/Building:		
Street/Road/Sector		
Area/Village/Taluka		
Landmark		
City:		
Pin Code:		
State:		
Landline:		

IRDAI Registration No. 103 IndusInd General Insurance Company Limited (Formerly known as Reliance General Insurance). An ISO 9001:2015 Certified Company For complete details on the benefits, coverage, terms & conditions and exclusions, do read the sales brochure, prospectus and policy wordings carefully before concluding sale. Registered & Corporate Office: 6th Floor, Oberoi Commerz, International Business Park, Oberoi Garden City, Off. Western Express Highway, Goregaon (E), Mumbai-400063. Corporate Identity Number: U66603MH2000PLC128300. IndusInd Motor Accidental Medical Expenses. UIN No.: IRDAN103RPMT0001V01202526. IGI/MCOM/CO/IMAME/PF/Ver. 1.0/300126.

Mobile:		
#Email:		
Source of Funds	☐ Business ☐ Profession ☐ Salary ☐ Agricultural Income ☐ Savings ☐ Others	
Do you have a GST Registration Number	☐ Yes ☐ No If yes please specify _____	
Period of Insurance (Please select one)	Requested Start Date D D / M M / Y Y Y Y ☐ 1 Year ☐ 2 Year ☐ 3 Year ☐ 4 Year ☐ 5 Year or Requested End Date D D / M M / Y Y Y Y *Maximum Cover available is 5 Years*	
#The Policy copy and all related documents shall be sent to the email ID provided above. If you wish to receive the Policy copy and related documents in physical form to the aforesaid communication address, please drop us an email at [RGI email address].		

CKYC DETAILS – SECTION I			
Date of Birth	D D / M M / Y Y Y Y	PAN No.	XXXXXXXXXXXXXXXXXXXX
If PAN No. Not available (Only Applicable for individuals)	Please attach Form 60 duly signed & attested.		
ABHA No. or ABHA ID:#		GST Registration No.: (If Applicable)	

ABHA (Ayushman Bharat Health Account) number is your 14 digit unique digital health identification number.

INSURED'S CKYC DETAILS – SECTION II (INDIVIDUALS)			
CKYC No.: Available	☐ Yes ☐ No	If Yes, Please Provide CKYC No.:	
If CKYC Number is not available:	Please attach any one of the following documents with self-attestation. Please tick on the document that you are attaching: 1. ☐ Driving License 2. ☐ Passport 3. ☐ Voter ID		

INSURED'S CKYC DETAILS – SECTION IV
If Name and Address is not the same as per the attached documents
Please Submit a declaration stating the Name and the Address is of the same person (Please find attached the Annexure – II for the same)

COVERAGE: (PLEASE SELECT BELOW)			
Cover Name	**Indemnity/ Benefit**	**Individual/ Floater**	**Limits (Amount)**
Base Covers (The following covers are included in the policy):			
1. Hospitalization covers			Please Select the Hospitalization Limit: ₹ _____ (Minimum ₹ 10,000 Maximum ₹ 50 Lakh)
1.1 Accidental Medical Hospitalization	Indemnity	Floater	Within Hospitalization limit; Room eligibility: Single Private Air-Conditioned Room (upto Deluxe Room)
1.2. Emergency Road Ambulance	Indemnity	Floater	₹ 3000 (Within Hospitalization limit)
1.3. Post-hospitalization	Indemnity	Floater	60 days; (Within Hospitalization limit)

2. Accidental Medical OPD • OPD Consultations • Pharmacy • Diagnostic tests • Minor Surgical Procedures	Indemnity	Floater	Please select one of the below ☐ Option 1: 10% of Hospitalization Limit ☐ Option 2: 20% of Hospitalization Limit (Please Note: Irrespective of choice above, the cover is subject to maximum ₹ 5 lakh) To be necessarily incurred within 15 days of occurrence of Accident
3. Doctor referral	*(Assistance Service)*		Telephonically arranging contact details of the nearest available Medical Practitioner
Optional Covers (Please select):			
4. Hospital Cash Cover	Benefit	Individual	☐ Yes ☐ No If Yes, please select the Daily Cash Amount: ₹ _____ (₹ 200 to 5000 per day in multiples of 100, not exceeding 2% of Hospitalization Limit) Payable for Maximum of 10 days Time Deductible: 24 hours

PAYMENT DETAILS

☐ Cash ☐ Credit Card ☐ Cheque ☐ DD ☐ Others

Cheque / DD No.		Cheque or DD Date	DD/MM/YYYY

PROPOSER'S BANK DETAILS (IN CASE OF REFUND)

Name of the Bank Account Holder	☐ Mr. ☐ Ms. ☐ Mrs. FIRST MIDDLE LAST		
Bank Account No.:		Account Type:	☐ Saving ☐ Current
Name of the Bank			
Branch			
IFSC Code (11 character code appearing on your cheque leaf)			

☐ I understand that any refund due on the premium payment / any payment / claims to be directly credited to my aforesaid Bank Account.*
*As per IRDAI, its mandatory that all payments made to the insured are only through electronic mode.
*Please attach a copy of signed cancelled cheque of the Bank Account of the insured only

NOMINEE'S DETAILS. Please give details of nomination

Name of the Nominee	Age of Nominee	Name of Appointee (if Nominee is Minor)	% of Claim	Relationship	Address	Mobile	Email ID

NOMINEE'S BANK DETAILS			
Name of the Bank Account Holder	☐ Mr. ☐ Ms. ☐ Mrs. F I R S T M I D D L E L A S T		
Bank Account No.:		Account:	☐ Saving ☐ Current
Name of the Bank			
Branch			
MICR Code (9 digit MICR code number of the bank and branch appearing on the cheque issued by the bank)			
IFSC Code (11 character code appearing on your cheque leaf)			

☐ I understand that any refund due on the premium payment / any payment / claims to be directly credited to my aforesaid Bank Account.*

*As per IRDAI, its mandatory that all payments made to the insured are only through electronic mode.

GENERAL DECLARATION:

I understand that as per the new AML/CFT Guidelines issued IndusInd General Insurance Co. Ltd will be verifying my details pertaining to KYC and PAN provided at the time of proposal.

I further, do hereby agree and consent that in the case of the event of a mismatch of information provided by me in the proposal form, identification proof, and address proof at the time of issuance of the policy. I request IndusInd General Insurance Company Limited to issue the policy with the details appearing as per my proposal form. I will be solely responsible for any consequences arising out of the difference in detail given by me during the verification of supporting documents provided by me at the time of issuance of the policy or otherwise.

AML Guidelines

"I/ We herby confirm that all premiums have been/ will be paid from bonafide sources and no premium have been/ will be paid out of the proceeds of crime related to any of the offence listed in Prevention of Money Laundering Act 2002. I understand that the company has the right to call for the documents to establish source of funds. The insur-ance company has the right to cancel the insurance contract in case I am/ have been found guilty by any compe-tent court of law under any of the statues, directly/ indirectly governing the prevention of Money Laundering in India.

Nationality	☐ Indian ☐ Non- Indian, If Non Indian please specify the country
Type of Organization	☐ Corporations ☐ Government ☐ Non Government Organizations ☐ Society ☐ Trust ☐ Partnership ☐ International Organization ☐ Cooperatives ☐ Section 25 companies

PEP DECLARATION:

Are you a Politically Exposed Person (PEP)?	☐ Yes ☐ No
If yes, please mention the position held	
Is any of your close relation or family member a PEP?	☐ Yes ☐ No
If yes, please mention the name and relation and the position held by such close relative/family member.	

I hereby declare that in future if me, any of my close relatives or any of my family member attains a position of PEP then I shall confirm the same to IndusInd General Insurance Co. Ltd as a mandate. I understand that this is a crucial information under the PMLA Rules and AML/ CFT Guidelines and shall confirm that the answers given by me is true. In case the company comes to know that this is a misrepresentation and concealment of information then the policy shall be put on hold for scrutiny by the company and I shall be solely responsible for the same.

Note :

"Politically Exposed Persons" (PEPs) shall have the meaning assigned to it under sub clause (db) of clause (1) of Rule 2 of the Prevention of Money Laundering (Maintenance of Records) Rules, 2005."

(db) "Politically Exposed Persons" (PEPs) are individuals who have been entrusted with prominent public functions by a foreign country, including the heads of States or Governments, senior politicians, senior government or judicial or military officers, senior executives of state-owned corporations and important political party officials".

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DECLARATION BY PROPOSER

- I/We hereby declare that the statements made by me/us in this Proposal Form are true to the best of my/our knowledge and belief and I/We hereby agree that this declaration shall form the basis of the contract between me/us and IndusInd General Insurance Company Limited. I/We also declare that, if any additions or alterations are carried out after the submission of this proposal form, then the same would be conveyed to the insurers immediately. I/We hereby declare that the contents of the form and documents have been fully explained to me/us and that I/We have fully understood the significance of the proposed contract. I/We agree to accept a policy subject to the condition prescribed by the company.
- I have read and understood the brochure, prospectus, sales literature & Policy wordings and confirm to abide by the same.
- 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;
- I declare and 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.
- 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.
- 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 and / or claims settlement and with any Governmental and / or Regulatory authority;
- This policy shall be voidable at the option of the Company in the event of mis-representation, mis-description of nondisclosure of any material particulars by the Proposer. Any person who, knowingly and with intent to defraud the Insurance Company or other persons, files a proposal of insurance containing any false information, or conceals for the purpose of misleading, information, information concerning any fact material thereto, commits a fraudulent act which will render the policy voidable at the company's sole discretion and result in a denial of insurance benefits.
- I agree and undertake to convey to the Company any change/alterations carried out in the risk proposed for insurance after submission of this Proposal form
- Ayushman Bharat Health Account (ABHA) Declaration: I on behalf of all person(s) to be insured provide consent to provide access to the medical and personal records/details of all person(s) to be insured, as are available in my/ our Ayushman Bharat Health Account (ABHA) and share the same with Third Party Administrators, Reinsurer (if applicable), Service Provider(s) of the Company and/or with any Governmental and/or Regulatory authority for the sole purposes of underwriting my/ our proposal and/ or for checking the authenticity of claims lodged by me/ us and/ or to comply with the applicable Law and Regulations.
- I/We here by state that the above mentioned address shall be taken as address on record for the purpose of GST
- I/We hereby confirm that the contents of the proposal form and connected documents have been fully explained to me/us and I/We have fully understood the significance of the proposed contract.

This proposal form was completed by

Name: _____

Place: _____

Date: _____

_____ _____

Signature of Proposer | Signature of Proposer & Company Seal

(*Only Applicable where proposer is a person with a disability and who has appointed an authorized representative. Please specify name of Authorizedrepresentative_____)

PROHIBITION OF REBATES - SECTION 41 OF INSURANCE ACT 1938 AS AMENDED BY INSURANCE LAWS (AMENDMENT) ACT, 2015.

1. 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.
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.

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SUPPORTING CONFIRMATION OF AGENT/BROKER/SM/CSO

I confirm the above signature to be of the registered owner of the vehicle proposed for insurance

Name of IRDAI Agent/Broker ☐ Mr. ☐ Ms. ☐ Mrs. F I R S T M I D D L E L A S T

Place: _____

Date: _____

(In case of Direct Business, Name & Signature of CSO / SM to be taken) _____

Signature of IRDAI Agent/Broker

ANNEXURE - II SELF DECLARATION FOR NAME AND ADDRESS MISMATCH:

SELF DECLARATION FORM

Date _____

To, IndusInd General Insurance Company Limited.,

Address _____

I Mr./Mrs./Ms. _____, state and declare that my name has been misspelt as _____ in _____ although my name is _____ however the same is incorrectly mentioned as _____ in the _____. I hereby agree and confirm that what is stated above is true and correct information.

_____

Signature of the Applicant Name Address