IndusInd GENERAL INSURANCE
FORMERLY RELIANCE GENERAL INSURANCE

Application Number: _____

Social Code: _____

AROGYA SANJEEVANI POLICY, INDUSIND GENERAL - PROPOSAL FORM

1. To be filled and signed by proposer
2. This proposal shall be the basis of contract for Policy issuance.
3. IndusInd General Insurance Company Ltd. (the "Company") is under no obligation to accept any proposal for insurance. The liability of the Company commences only when this proposal is accepted by the Company and the premium is received. If the Company accepts a proposal for insurance, it shall be subject to the Policy Terms and Conditions.

For Office Use Only

A) INTERMEDIARY DETAILS (To be filled in BLOCK LETTERS)

Intermediary Name		Code	
IMD Employee Name		Code	
IMD Branch Name		Code	

B. PROPOSER DETAILS (To be filled in BLOCK LETTERS)

Name of Proposer* (IN CAPITAL LETTERS)	○ Mr. ○ Mrs. ○ Ms. ○ M/S. F I R S T M I D D L E L A S T	
Address (IN CAPITAL LETTERS)*		
		Pin Code*
Residence Number		Mobile*
Gender*	○ Male ○ Female ○ Transgender	Marital Status (Married/Single/Others)* _____
Maiden Name*		
D.O.B* (Mandatory)	D D / M M / Y Y Y Y	PAN No.*_____ (Mandatory) If not provided Form 60 required.
UID Aadhaar No.*		Email Id*
Nationality*		CKYC No. (for Individual customer)
Do you have a GST Registration Number	○ Yes ○ No	
If Yes, please specify		
Source of Funds	○ Business ○ Profession ○ Salary ○ Agricultural Income ○ Savings ○ Others	
Occupations	○ Salaried ○ Self Employed ○ Other	
Monthly Income	○ Upto ₹ 20,000 ○ ₹ 20,001 to ₹ 50,000 ○ ₹ 50,001 to ₹ 1,00,000 ○ ₹ 1,00,001 and above	
Premium Payment Option*	○ Annually ○ Half Yearly ○ Quarterly ○ Monthly	
Social Number		

*Fields are Mandatory

IndusInd GENERAL INSURANCE
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C. PROPOSER'S BANK DETAILS

1. Name of the Bank Account Holder	○ Mr. ○ Ms. ○ Mrs. F I R S T M I D D L E L A S T		
2. Bank Account No.:		3. Account:	○ Saving ○ Current
4. Name of the Bank			
5. Branch			
6. MICR Code (9 digit MICR code number of the bank and branch appearing on the cheque issued by the bank)			
7. 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.

D. NOMINATION DETAILS

The nominee as declared hereunder shall become eligible for claim payment under the Policy as per the terms and conditions of the Policy, in the event of the death of the Policyholder. The receipt of proceeds by the nominee would be sufficient discharge to the Company. Nominee for all other person (s) proposed shall be the proposer himself/herself.

Name of Nominee	D.O.B.	Reationship With Insured	Address of Nominee
	D D / M M / Y Y Y Y		

If the Nominee is Minor, Name And Address of Appointee and Relationship with Minor:

Name	Mobile No.	Email	Aadhaar Number/ Virtual ID	Date of Birth	Relationship

E. POLICY DETAILS (Tick the required option)

Policy Type:	○ Individual ○ Floater
Requested Policy Start Date:	D D / M M / Y Y Y Y
Sum Insured Option:	○ 50,000 ○ 1,00,000 ○ 1,50,000 ○ 2,00,000 ○ 2,50,000 ○ 3,00,000 ○ 3,50,000 ○ 4,00,000 ○ 4,50,000 ○ 5,00,000 ○ 5,50,000 ○ 6,00,000 ○ 6,50,000 ○ 7,00,000 ○ 7,50,000 ○ 8,00,000 ○ 8,50,000 ○ 9,00,000 ○ 9,50,000 ○ 10,00,000

F. PERSONAL DETAILS

Details		Member 1	Member 2	Member 3	Member 4	Member 5	Member 6	Member 7	Member 8
Name	First Name								
	Last Name								
DOB		DD/MM/YYYY	DD/MM/YYYY	DD/MM/YYYY	DD/MM/YYYY	DD/MM/YYYY	DD/MM/YYYY	DD/MM/YYYY	DD/MM/YYYY
Gender									
Nationality									
Relationship with Proposer									

VACCINATION & COVID-19 MEDICAL QUESTIONS

VACCINATION DETAILS	MEMBER 1	MEMBER 2	MEMBER 3	MEMBER 4	MEMBER 5	MEMBER 6
ID Proof Verified/Submitted for vaccination registration						
Beneficiary Reference ID						
Date of Dose & Batch No						
Have you and/or any of your immediate family members travelled outside India in the last 45 days or do you plan to travel outside India during the next 6 months?	O Yes O No	O Yes O No	O Yes O No	O Yes O No	O Yes O No	O Yes O No
Have you and/or any of your immediate family members tested positive for COVID-19 or are awaiting results of such a test or been advised to be under quarantine due to COVID-19?	O Yes O No	O Yes O No	O Yes O No	O Yes O No	O Yes O No	O Yes O No
Are you and/or any of your immediate family members currently suffering from or in the last 2 months, have suffered from fever, persistent cough, sore throat, breathing difficulties, gastrointestinal symptoms (vomiting/ diarrhea)?	O Yes O No	O Yes O No	O Yes O No	O Yes O No	O Yes O No	O Yes O No

G. PLEASE TICK THE PRE-EXISTING DISEASE AS PER INSURED:

Lifestyle / Disease Questionnaire		Member 1		Member 2		Member 3		Member 4	
Sr. No.	Have you suffered from any of the following illness/ sickness or medical conditions during the last 4 year? (You requested to disclose these information in a truthful manner. Any wrong information can lead to hassles at the time of claims, if any)	Do you suffer from?	First Diagnosis Date	Do you suffer from?	First Diagnosis Date	Do you suffer from?	First Diagnosis Date	Do you suffer from?	First Diagnosis Date
1.	Diabetes, Impaired Glucose Tolerance (Pre-Diabetes), Thyroid/ Pituitary disorder?	O Yes O No	dd/mm/yy	O Yes O No	dd/mm/yy	O Yes O No	dd/mm/yy	O Yes O No	dd/mm/yy
2.	High Blood Pressure/ Hypertension, Low Blood Pressure, Chest Pain, any ailment/ diseases of the Heart?	O Yes O No	dd/mm/yy	O Yes O No	dd/mm/yy	O Yes O No	dd/mm/yy	O Yes O No	dd/mm/yy
3.	Undertaken any surgery or a surgery been advised and have surgery still pending?	O Yes O No	dd/mm/yy	O Yes O No	dd/mm/yy	O Yes O No	dd/mm/yy	O Yes O No	dd/mm/yy
4.	Asthma, Bronchitis, Tuberculosis, Breathing difficulties or disorder of the lung/respiratory track?	O Yes O No	dd/mm/yy	O Yes O No	dd/mm/yy	O Yes O No	dd/mm/yy	O Yes O No	dd/mm/yy
5.	HIV/AIDs, any sexually transmitted diseases or any ailment of the immune system?	O Yes O No	dd/mm/yy	O Yes O No	dd/mm/yy	O Yes O No	dd/mm/yy	O Yes O No	dd/mm/yy
6.	Jaundice, Liver Cirrhosis, Fatty Liver Disease, Gall Bladder Stone, Pancreatic Disease, Hepatitis B or any other disorder of the liver or pancreas ?	O Yes O No	dd/mm/yy	O Yes O No	dd/mm/yy	O Yes O No	dd/mm/yy	O Yes O No	dd/mm/yy
7.	Ulcer of the stomach/duodenal, piles/anal fistula, Inflammatory Bowel Diseasesor any other ailment of the digestive system?	O Yes O No	dd/mm/yy	O Yes O No	dd/mm/yy	O Yes O No	dd/mm/yy	O Yes O No	dd/mm/yy

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. Arogya Sanjeevani Policy, IndusInd General. UIN: RELHLIP21001V012021. IGI/MCOM/CO/HL-06/AROGYA SANJEEVANI POLICY /PF/Ver. 1.1/030424

8.	Tumour - benign or malignant or any growth, cyst, mass anywhere in the body?	O Yes O No	dd/mm/yy	O Yes O No	dd/mm/yy	O Yes O No	dd/mm/yy	O Yes O No	dd/mm/yy
9.	Arthritis, Spondylosis of any other disorder of bone, muscles or joints, Avascular Necrosis?	O Yes O No	dd/mm/yy	O Yes O No	dd/mm/yy	O Yes O No	dd/mm/yy	O Yes O No	dd/mm/yy
10.	Kidney Failure, Stone in kidney and urinary tract, Prostate disorder or any other kidney/urinary tract disorder? Any time you have undergone a dialysis?	O Yes O No	dd/mm/yy	O Yes O No	dd/mm/yy	O Yes O No	dd/mm/yy	O Yes O No	dd/mm/yy
11.	Stroke, Epilepsy (fits), Paralysis or other nervous system (Brain, spinal cord, etc) disorder?	O Yes O No	dd/mm/yy	O Yes O No	dd/mm/yy	O Yes O No	dd/mm/yy	O Yes O No	dd/mm/yy
12.	Diseases of the Ear/Nose/Throat/Teeth/ Eye (please mention Dioptres in case of refractory error) ?	O Yes O No	dd/mm/yy	O Yes O No	dd/mm/yy	O Yes O No	dd/mm/yy	O Yes O No	dd/mm/yy
13.	Anemia, Leukaemia, Lymphoma or any other blood / Lymphatic system disease or Sarcoidosis, Papulosquamous disorder of skin ?	O Yes O No	dd/mm/yy	O Yes O No	dd/mm/yy	O Yes O No	dd/mm/yy	O Yes O No	dd/mm/yy
14.	Psychiatric / Mental illnesses or sleep disorder, Alzheimers Disease, Parkinsons Disease?	O Yes O No	dd/mm/yy	O Yes O No	dd/mm/yy	O Yes O No	dd/mm/yy	O Yes O No	dd/mm/yy
15.	Any disability or sickness from birth / early childhood?	O Yes O No	dd/mm/yy	O Yes O No	dd/mm/yy	O Yes O No	dd/mm/yy	O Yes O No	dd/mm/yy
16.	Uterine Fibroid, Fibroadenoma breast or any other Gynaecological (Female reproductive system)/ breast disorder?	O Yes O No	dd/mm/yy	O Yes O No	dd/mm/yy	O Yes O No	dd/mm/yy	O Yes O No	dd/mm/yy
17.	Been addicted to alcohol, narcotics, and habit forming drugs or been under detoxication therapy?	O Yes O No	dd/mm/yy	O Yes O No	dd/mm/yy	O Yes O No	dd/mm/yy	O Yes O No	dd/mm/yy
18.	Been under any regular medication (self/ prescribed) ?	O Yes O No	dd/mm/yy	O Yes O No	dd/mm/yy	O Yes O No	dd/mm/yy	O Yes O No	dd/mm/yy
19.	Undertaken any lab/blood tests, imaging tests viz. scans/MRI in the last 5 years other than routine health check-up or pre-employment check-up?	O Yes O No	dd/mm/yy	O Yes O No	dd/mm/yy	O Yes O No	dd/mm/yy	O Yes O No	dd/mm/yy
20.	Is any of the insured pregnant? If yes please mention the expected date of delivery. Any complication during current or earlier pregnancy?	O Yes O No	dd/mm/yy	O Yes O No	dd/mm/yy	O Yes O No	dd/mm/yy	O Yes O No	dd/mm/yy
21.	Has an ailment or disability or deformity	O Yes O No	dd/mm/yy	O Yes O No	dd/mm/yy	O Yes O No	dd/mm/yy	O Yes O No	dd/mm/yy
22.	Other Please specify		dd/mm/yy		dd/mm/yy		dd/mm/yy		dd/mm/yy
23.	If you have ticked 'Yes' in any of the boxes above, please name the disease /condition here.								

G 1. PLEASE TICK THE PRE-EXISTING DISEASE AS PER INSURED:

Lifestyle / Disease Questionnaire		**Member 5**		**Member 6**		**Member 7**		**Member 8**	
Sr. No.	Have you suffered from any of the following illness/ sickness or medical conditions during the last 4 year? (You requested to disclose these information in a truthful manner. Any wrong information can lead to hassles at the time of claims, if any)	Do you suffer from?	First Diagnosis Date	Do you suffer from?	First Diagnosis Date	Do you suffer from?	First Diagnosis Date	Do you suffer from?	First Diagnosis Date
1.	Diabetes, Impaired Glucose Tolerance (Pre-Diabetes), Thyroid/ Pituitary disorder?	O Yes O No	dd/mm/yy	O Yes O No	dd/mm/yy	O Yes O No	dd/mm/yy	O Yes O No	dd/mm/yy

2.	High Blood Pressure/ Hypertension, Low Blood Pressure, Chest Pain, any ailment/ diseases of the Heart?	O Yes O No	dd/mm/yy	O Yes O No	dd/mm/yy	O Yes O No	dd/mm/yy	O Yes O No	dd/mm/yy
3.	Undertaken any surgery or a surgery been advised and have surgery still pending?	O Yes O No	dd/mm/yy	O Yes O No	dd/mm/yy	O Yes O No	dd/mm/yy	O Yes O No	dd/mm/yy
4.	Asthma, Bronchitis, Tuberculosis, Breathing difficulties or disorder of the lung/respiratory track?	O Yes O No	dd/mm/yy	O Yes O No	dd/mm/yy	O Yes O No	dd/mm/yy	O Yes O No	dd/mm/yy
5.	HIV/AIDs, any sexually transmitted diseases or any ailment of the immune system?	O Yes O No	dd/mm/yy	O Yes O No	dd/mm/yy	O Yes O No	dd/mm/yy	O Yes O No	dd/mm/yy
6.	Jaundice, Liver Cirrhosis, Fatty Liver Disease, Gall Bladder Stone, Pancreatic Disease, Hepatitis B or any other disorder of the liver or pancreas ?	O Yes O No	dd/mm/yy	O Yes O No	dd/mm/yy	O Yes O No	dd/mm/yy	O Yes O No	dd/mm/yy
7.	Ulcer of the stomach/duodenal, piles/anal fIstula, Inflammatory Bowel Diseasesor any other ailment of the digestive system?	O Yes O No	dd/mm/yy	O Yes O No	dd/mm/yy	O Yes O No	dd/mm/yy	O Yes O No	dd/mm/yy
8.	Tumour - benign or malignant or any growth, cyst, mass anywhere in the body?	O Yes O No	dd/mm/yy	O Yes O No	dd/mm/yy	O Yes O No	dd/mm/yy	O Yes O No	dd/mm/yy
9.	Arthritis, Spondylosis of any other disorder of bone, muscles or joints, Avascular Necrosis?	O Yes O No	dd/mm/yy	O Yes O No	dd/mm/yy	O Yes O No	dd/mm/yy	O Yes O No	dd/mm/yy
10.	Kidney Failure, Stone in kidney and urinary tract, Prostate disorder or any other kidney/urinary tract disorder? Any time you have undergone a dialysis?	O Yes O No	dd/mm/yy	O Yes O No	dd/mm/yy	O Yes O No	dd/mm/yy	O Yes O No	dd/mm/yy
11.	Stroke, Epilepsy (fits), Paralysis or other nervous system (Brain, spinal cord, etc) disorder?	O Yes O No	dd/mm/yy	O Yes O No	dd/mm/yy	O Yes O No	dd/mm/yy	O Yes O No	dd/mm/yy
12.	Diseases of the Ear/Nose/Throat/Teeth/ Eye (please mention Dioptres in case of refractory error) ?	O Yes O No	dd/mm/yy	O Yes O No	dd/mm/yy	O Yes O No	dd/mm/yy	O Yes O No	dd/mm/yy
13.	Anemia, Leukaemia, Lymphoma or any other blood / Lymphatic system disease or Sarcoidosis, Papulosquamous disorder of skin ?	O Yes O No	dd/mm/yy	O Yes O No	dd/mm/yy	O Yes O No	dd/mm/yy	O Yes O No	dd/mm/yy
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15.	Any disability or sickness from birth / early childhood?	O Yes O No	dd/mm/yy	O Yes O No	dd/mm/yy	O Yes O No	dd/mm/yy	O Yes O No	dd/mm/yy
16.	Uterine Fibroid, Fibroadenoma breast or any other Gynaecological (Female reproductive system)/ breast disorder?	O Yes O No	dd/mm/yy	O Yes O No	dd/mm/yy	O Yes O No	dd/mm/yy	O Yes O No	dd/mm/yy
17.	Been addicted to alcohol, narcotics, and habit forming drugs or been under detoxication therapy?	O Yes O No	dd/mm/yy	O Yes O No	dd/mm/yy	O Yes O No	dd/mm/yy	O Yes O No	dd/mm/yy
18.	Been under any regular medication (self/ prescribed) ?	O Yes O No	dd/mm/yy	O Yes O No	dd/mm/yy	O Yes O No	dd/mm/yy	O Yes O No	dd/mm/yy
19.	Undertaken any lab/blood tests, imaging tests viz. scans/MRI in the last 5 years other than routine health check-up or pre-employment check-up?	O Yes O No	dd/mm/yy	O Yes O No	dd/mm/yy	O Yes O No	dd/mm/yy	O Yes O No	dd/mm/yy
20.	Is any of the insured pregnant? If yes please mention the expected date of delivery. Any complication during current or earlier pregnancy?	O Yes O No	dd/mm/yy	O Yes O No	dd/mm/yy	O Yes O No	dd/mm/yy	O Yes O No	dd/mm/yy
21.	Has an ailment or disability or deformity	O Yes O No	dd/mm/yy	O Yes O No	dd/mm/yy	O Yes O No	dd/mm/yy	O Yes O No	dd/mm/yy
22.	Other Please specify		dd/mm/yy		dd/mm/yy		dd/mm/yy		dd/mm/yy

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23.	If you have ticked 'Yes' in any of the boxes above, please name the disease /condition here.								

H. FAMILY PHYSICIAN'S DETAILS

Name of Family Physician:	○Mr. ○Ms. ○Mrs. F I R S T M I D D L E L A S T		
Contact Number		Email Id	

I. EXISTING HEALTH INSURANCE POLICY DETAILS, IF ANY

Member	Insurer Name	Policy Number	Start date	End date	Sum Insured	CB (% or Amount)	Claim under the policy in past 3 years
Member 1						Y/N	Y/N
Member 2						Y/N	Y/N
Member 3						Y/N	Y/N
Member 4						Y/N	Y/N
Member 5						Y/N	Y/N
Member 6						Y/N	Y/N
Member 7						Y/N	Y/N
Member 8						Y/N	Y/N

If you would like to port any of these policies, please fill up the portability form

Please provide/Attach previous policy copies along with claim documents with respect to above mentioned details

J. PREMIUM PAYMENT DETAILS

Payment by:	Cheque*/DD*/ Credit Card#/Debit Card # (Tick whichever is applicable)		
	○Cheque ○DD ○Credit Card ○Debit Card ○NEFT ○Net Banking		
Cheque or DD Amount		Amount in words	
Bank Name			
Cheque No./DD No./Card No.		Cheque/DD Date	D D / M M / Y Y Y Y
Name of the Premium payer			

*In case of payment made through cheque / DD then please issue an A/c payee instrument in favour of "IndusInd General Insurance Company limited" #In case of payment made through Credit / Debit Card the Card needs to be in the name of the Proposer

K. DECLARATION & WARRANTY ON BEHALF OF ALL PERSONS PROPOSED TO BE INSURED

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 insu red/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
6. I consent to receive information from the Company through physical, electronic or telecommunication means from time to time.
7. I here by state that the above mentioned address shall be taken as address on record for the purpose of GST.

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8. I hereby confirm that the contents of the proposal form and connected documents have been fully explained to me and I have fully understood the significance of the proposed contract

PLACE: _____ **DATE:** D D / M M / Y Y Y Y _____

SIGNATURE

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.

PEP DECLARATION:

Are you a Politically Exposed Person (PEP)?	O Yes O No
If yes, please mention the position held	
Is any of your close relation or family member a PEP?	O Yes O 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".

L. AML GUIDELINES

1. I/We hereby confirm that all premiums have been/will be paid from bonafide sources and no premiums have been/will be paid out of proceeds of crime related to any of the offence listed in Prevention of Money Laundering Act, 2002.
2. I understand that the company has the right to call for document to established sources of funds.
3. The Insurance company has right to cancel the insurance contract in case I am/have been found guilty by any competent court of law under any of the statues, directly or indirectly governing the prevention of money laundering in India.

PLACE: _____ **DATE:** D D / M M / Y Y Y Y _____

SIGNATURE OF THE PROPOSER

IndusInd GENERAL INSURANCE
FORMERLY RELIANCE GENERAL INSURANCE

M. PROHIBITION OF REBATES - SECTION 41 OF THE 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.

Vernacular Declaration stating that the contents of this proposal form have been read over & fully explained to me in _____ language. I further confirm & declare that contents read over & explained to me have been understood by me. _____

_____

_____

Signature/Thumb Impression of the Proposer:_____

Identified by Name & Signature: _____

DATE: D D / M M / Y Y Y Y **PLACE:** _____

Vernacular Declaration stating that the contents of this proposal form have been read over & fully explained to me in _____ language. I further confirm & declare that contents read over & explained to me have been understood by me. _____

_____

_____

Signature/Thumb Impression of the Proposer:_____

Identified by Name & Signature: _____

PLACE: _____ **DATE:** D D / M M / Y Y Y Y

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IndusInd
GENERAL INSURANCE
FORMERLY RELIANCE GENERAL INSURANCE

N. ACKNOWLEDGMENT FOR PROPOSAL

Please retain this counterfoil for your records (on behalf of IndusInd General Insurance Company Limited)

NOT VALID AGAINST CASH Proposal Form No. _____

Date: DD/MM/YYYY

We acknowledge the receipt of payment of ₹_____ vide cheque/DD _____from

Mr./Mrs./Ms. _____

Please note that this is only an acknowledgment receipt and does not amount to acceptance of risk or commencement of Policy. IndusInd General Insurance Company Limited is not liable for any claim between the time that the proposal amount is received and Policy start date. The validity of receipt is subject to realization of proposal amount. Acceptance of proposal and issuance of policy shall be subject to receipt of completed proposal for, premium payment, medical reports (wherever applicable) and underwriting decision of the Company.

Name of the Employee:_____

Signature of the Employee:_____ Company Seal & Stamp_____

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. Arogya Sanjeevani Policy, IndusInd General. UIN: RELHLIP21001V012021. IGI/MCOM/CO/HL-06/AROGYA SANJEEVANI POLICY /PF/Ver. 1.1/030424