

INDUSIND HEALTH GLOBAL - PROPOSAL FORM

Please 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. IndusInd General Insurance Company Ltd. (the "Company") is under no obligation to accept any proposal for insurance. The liability of the Company does not commence until the proposal is accepted and underwritten by the Company and premium is received. If the Company accepts a proposal for insurance, it shall be subject to the Policy Terms and Conditions.

INTERMEDIARY DETAILS (To Be Filled In BLOCK LETTERS)			
Intermediary Name:		Code:	
IMD Branch Name:		Code:	
Sales Manager Name:		Code:	
PROPOSER'S DETAILS (All The Details Are Mandatory)			
Name Of The Proposer Mr. / Mrs. / Ms.: F I R S T M I D D L E L A S T			
Permanent Address:			
City:	State:	Pin Code:	
Communication Address Same As Permanent Address / Different From Permanent Address (Specify Below)			
City:	State:	Pin Code:	
Contact Number	Primary No.:	Secondary No.:	
E-mail ID			
Date Of Birth	D D / M M / Y Y Y Y	Nationality	
Gender	Male / Female / Other		
Marital Status	Married / Single / Other		
Maiden Name	(if applicable)		
Occupation	Salaried / Self-Employed/ Others, Pls. specify		
Annual Income			
Source of Income	Business / Profession / Salary / Agricultural Income / Savings / Others		
(Please Fill At Least One):			
PAN No. _____ Form 60 is Mandatory If PAN Is Not Provided			
GST Registration No.: (If Applicable)		CKYC No.: (For Individual Customer)	
Do You Have An E-Insurance Account (E-IA)?			
<input type="radio"/> Yes, Please Provide E-Insurance Account (E-IA) No. _____ <input type="radio"/> No, I Hereby Declare That "I Would Like To Receive My Insurance Policy And All The Information Related To The Proposed Insurance Policy Through Insurance Repository"			



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Do You Have An Existing Health/Non Health Insurance Policy With Us?	Yes / No	Policy No.
Are You An Employee Of IndusInd General Insurance Company (IGICL)?	Yes / No	Employee ID.
Were You Referred By An Employee Of IndusInd General Insurance Company (IGICL)?	Yes / No	Name Employee ID.

PROPOSER'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 Name.:		Account Type: Saving / Current
Bank Account Number:		Branch
IFSC Code (11 character Code Appearing On Your Cheque Leaf)		
MICR Code (9 Digit MICR Code Number Of The Bank And Branch Appearing On The Cheque Issued By The Bank)		
<input type="checkbox"/> 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.		

NOMINATION DETAILS

The nominee as declared hereunder shall become eligible for 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	Mobile No.	Email	Date Of Birth (DD/MM/YYYY)	Relationship With Proposer	Address of Nominee
XXXXXXXXXXXXXXXXXX	XXXXXXXXXX	XXXXXXXXXX	XXXXXXXXXX	XXXXXXXXXX	XXXXXXXXXX
XXXXXXXXXXXXXXXXXX	XXXXXXXXXX	XXXXXXXXXX	XXXXXXXXXX	XXXXXXXXXX	XXXXXXXXXX

Note: If Nominee Is A Minor, Please Also Provide Appointee Details

Name of Nominee	Mobile No.	Email	Date Of Birth (DD/MM/YYYY)	Relationship With Nominee	Address of Nominee
XXXXXXXXXXXXXXXXXX	XXXXXXXXXX	XXXXXXXXXX	XXXXXXXXXX	XXXXXXXXXX	XXXXXXXXXX
XXXXXXXXXXXXXXXXXX	XXXXXXXXXX	XXXXXXXXXX	XXXXXXXXXX	XXXXXXXXXX	XXXXXXXXXX

POLICY DETAILS (✓) Tick the required option)(All fields are mandatory)

Cover Type:	Individual / Family Floater	
Policy Tenure:	1 year / 2 years / 3 years	
Plan Type:	Please select Global Plan:	
	Elite / Elite+ / Royal / Royal+	
	Please select India Plan*	
	Basic / Comprehensive / Not Required	
Sum Insured	Global Cover USD Per Annum	India Cover (If Opted Above) INR Per Annum
Geographical Coverage Under Global Cover:	Worldwide / Worldwide Excluding USA & Canada	


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Optional Covers*					
Waiver Of Co-Payment:	Yes / No				
Voluntary Co-payment:	Yes / No If Yes, Opt For Below Co-Payment 10% / 20%				
Change In Pre-Existing Waiting Period:	12 Months / 24 months / Not Required (If "Not Required", Then PED Waiting Period Is 36 Months)				
*Additional Premium Or Discounts Shall Apply					
Multi Trip Rider	Yes / No				
If Yes, The Following Sum Insured Shall Be Made Available Basis The Global Sum Insured Selected Above:					
Global Sum Insured (USD Per Annum)	1.5 Lakh	2.5 Lakh	5 Lakh	7.5 Lakh	10 Lakh
Multi-Trip Rider Sum Insured	1 Lakh	1.5 Lakh	2 Lakh	3 Lakh	5 Lakh
Max. Trip Duration Covered	30 Days / 45 Days /60 Days / 90 Days				
Geographical Coverage Under Multi Trip Rider	Worldwide / Worldwide Excluding USA & Canada				
Details of Person(s) Proposed to be Insured					
Section A: Personal Details					
Details (*Marked Details Are Compulsory)	Member 1	Member 2	Member 3	Member 4	
Name Of Insured Person:*	XXXXXXXXXXXXXXXX	XXXXXXXXXXXXXXXX	XXXXXXXXXXXXXXXX	XXXXXXXXXXXXXXXX	
Gender(M/F/Others)*	XXXXXXXXXXXXXXXX	XXXXXXXXXXXXXXXX	XXXXXXXXXXXXXXXX	XXXXXXXXXXXXXXXX	
Date Of Birth*	XXXXXXXXXXXXXXXX	XXXXXXXXXXXXXXXX	XXXXXXXXXXXXXXXX	XXXXXXXXXXXXXXXX	
Relationship With Proposer*	XXXXXXXXXXXXXXXX	XXXXXXXXXXXXXXXX	XXXXXXXXXXXXXXXX	XXXXXXXXXXXXXXXX	
Nationality*	India Other	India Other	India Other	India Other	
Country Of Residence*	India Other	India Other	India Other	India Other	
Passport Number	XXXXXXXXXXXXXXXX	XXXXXXXXXXXXXXXX	XXXXXXXXXXXXXXXX	XXXXXXXXXXXXXXXX	
ABHA Number or ABHA ID	XXXXXXXXXXXXXXXX	XXXXXXXXXXXXXXXX	XXXXXXXXXXXXXXXX	XXXXXXXXXXXXXXXX	
Occupation*	XXXXXXXXXXXXXXXX	XXXXXXXXXXXXXXXX	XXXXXXXXXXXXXXXX	XXXXXXXXXXXXXXXX	
Annual Income (Rs.)*	XXXXXXXXXXXXXXXX	XXXXXXXXXXXXXXXX	XXXXXXXXXXXXXXXX	XXXXXXXXXXXXXXXX	
Height (In cms.)	XXXXXXXXXXXXXXXX	XXXXXXXXXXXXXXXX	XXXXXXXXXXXXXXXX	XXXXXXXXXXXXXXXX	
Weight (In kgs.)	XXXXXXXXXXXXXXXX	XXXXXXXXXXXXXXXX	XXXXXXXXXXXXXXXX	XXXXXXXXXXXXXXXX	
Medical Questions	Member 1	Member 2	Member 3	Member 4	
Name of the Insured Person :					
First Name :					
Last Name :					
1. Pre-Existing Disease :					



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Disease Since : _____

2. Has planned a surgery Yes / No. If Yes, please provide the below details _____

a Please share details for your surgery <name of the person proposed to be insured>

• Exact diagnosis:				
• Diagnosis Date:	DD/MM/YYYY	DD/MM/YYYY	DD/MM/YYYY	DD/MM/YYYY
• Consulting Date:	DD/MM/YYYY	DD/MM/YYYY	DD/MM/YYYY	DD/MM/YYYY
• Hospital Name:				

b Please share details of your past surgery _____

3. Takes medicines regularly Yes / No. If Yes, please provide the below details _____

a Please share details for your current medication <name of the person proposed to be insured>

• Exact diagnosis:				
• Diagnosis Date:	DD/MM/YYYY	DD/MM/YYYY	DD/MM/YYYY	DD/MM/YYYY
• Consulting Date:	DD/MM/YYYY	DD/MM/YYYY	DD/MM/YYYY	DD/MM/YYYY
• Medicine Name:				

b Please share details of your treatment _____

4. Has been advised investigation or further tests Yes / No. If Yes, please provide the below details _____

a Please provide details about investigation suggested by your doctor <name of the person proposed to be insured>

• Date of tests:	DD/MM/YYYY	DD/MM/YYYY	DD/MM/YYYY	DD/MM/YYYY
• Type of tests:				
• Findings of tests				

Please the investigation tests results attach _____

5. Was hospitalized in past Yes / No. If Yes, please provide the below details _____

a Please share details for your past medical condition <name of the person proposed to be insured>

• Exact diagnosis:				
• Diagnosis Date:				
• Consulting Date:				
• Hospital Name				

b Please share details of your past medical condition _____



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6. Is expecting a baby Yes / No. If Yes, please provide the below details _____

a Please share your expected delivery date with us

7. Has any of the persons to be insured ever filed a claim with their current / previous Insurer ? _____

Please Describe _____

8. Has any proposal of life insurance, Critical illness or health insurance been declined, cancelled or charged a higher premium ? _____

Please Describe _____

9. Is any person proposed to be insured presently suffering (or suffered in the past 15 days) from any disease/illness/ accident/injury other than common cold or fever? _____

10. Are Any Of The Persons Proposed For Insurance Covered Under Any Other Health Insurance Policy With The Company? _____

Medical Questions	Member 5	Member 6	Member 7	Member 8
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Name of the Insured Person :

First Name :

Last Name :

1. Pre-Existing Disease :

Disease Since :

2. Has planned a surgery Yes / No. If Yes, please provide the below details _____

a Please share details for your surgery <name of the person proposed to be insured>

• Exact diagnosis:

• Diagnosis Date:

DD/MM/YYYY

DD/MM/YYYY

DD/MM/YYYY

DD/MM/YYYY

• Consulting Date:

DD/MM/YYYY

DD/MM/YYYY

DD/MM/YYYY

DD/MM/YYYY

• Hospital Name:

b Please share details of your past surgery _____

3. Takes medicines regularly Yes / No. If Yes, please provide the below details _____

a Please share details for your current medication <name of the person proposed to be insured>

• Exact diagnosis:

• Diagnosis Date:

DD/MM/YYYY

DD/MM/YYYY

DD/MM/YYYY

DD/MM/YYYY

• Consulting Date:

DD/MM/YYYY

DD/MM/YYYY

DD/MM/YYYY

DD/MM/YYYY

• Medicine Name:



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b Please share details of your treatment _____

4. Has been advised investigation or further tests Yes / No. If Yes, please provide the below details _____

a Please provide details about investigation suggested by your doctor <name of the person proposed to be insured>

• Date of tests:	DD/MM/YYYY	DD/MM/YYYY	DD/MM/YYYY	DD/MM/YYYY
• Type of tests:				
• Findings of tests				

Please the investigation tests results attach _____

5. Was hospitalized in past Yes / No. If Yes, please provide the below details _____

a Please share details for your past medical condition <name of the person proposed to be insured>

• Exact diagnosis:				
• Diagnosis Date:				
• Consulting Date:				
• Hospital Name				

b Please share details of your past medical condition _____

6. Is expecting a baby Yes / No. If Yes, please provide the below details _____

a Please share your expected delivery date with us _____

7. Has any of the persons to be insured ever filed a claim with their current / previous Insurer ? _____

Please Describe _____

8. Has any proposal of life insurance, Critical illness or health insurance been declined, cancelled or charged a higher premium ? _____

Please Describe _____

9. Is any person proposed to be insured presently suffering (or suffered in the past 15 days) from any disease/illness/ accident/injury other than common cold or fever? _____



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10.) Are Any Of The Persons Proposed For Insurance Covered Under Any Other Health Insurance Policy With The Company?_____

Lifestyle Questions

Does Any Of The Persons Proposed To Be Insured Use Tobacco Products/Cigarettes Or Drink Alcohol?	Yes / No	Yes / No	Yes / No	Yes / No
Do Any Immediate Family Member (Father, Mother, Brother Or Sister) Of Any Of Persons Proposed To Be Insured Have/ Had In The Past: Diabetes, Hypertension, Cancer, Heart Attack, Or Stroke?	Yes / No	Yes / No	Yes / No	Yes / No

Note: The Company May Apply A Risk Loading Upto 300% On The Premium Payable (Based Upon The Declarations Made In The Proposal Form And The Health Status Of The Members Proposed To Be Insured). These Loadings Would Be Applied From The First Policy And Its Subsequent Renewals With The Company.

Any Loadings, If Applicable, Shall Be Suitably Intimated To The Proposer Based On The Assessment Of The Proposal Form And/Or Medical Tests. The Proposer Shall Be Required To Pay An Additional Premium Within 7 Days Of Such Intimation.

The Company Shall Only Be At Any Risk Once It Receives And Accepts This Additional Premium. In The Event Of Non-Receipt Of This Additional Premium Within The Stipulated Time, Company Shall Cancel The Proposal.

SECTION B: EXISTING HEALTH INDEMNITY INSURANCE DETAILS

Details	Member 1	Member 2	Member 3	Member 4
Name Of Insurer:	XXXXXXXXXXXX	XXXXXXXXXXXX	XXXXXXXXXXXX	XXXXXXXXXXXX
Policy No.	XXXXXXXXXXXX	XXXXXXXXXXXX	XXXXXXXXXXXX	XXXXXXXXXXXX
Policy: From	DD/MM/YYYY	DD/MM/YYYY	DD/MM/YYYY	DD/MM/YYYY
Period: To	DD/MM/YYYY	DD/MM/YYYY	DD/MM/YYYY	DD/MM/YYYY
Date Of First Enrollment:	DD/MM/YYYY	DD/MM/YYYY	DD/MM/YYYY	DD/MM/YYYY
Geography Of Coverage ('Abroad' Shall Exclude Travel Insurance)	India Abroad India and Abroad	India Abroad India and Abroad	India Abroad India and Abroad	India Abroad India and Abroad
Is USA and Canada Covered?	Yes / No	Yes / No	Yes / No	Yes / No
Sum Insured Global (If Applicable):	Currency_____ SI_____	Currency_____ SI_____	Currency_____ SI_____	Currency_____ SI_____
Sum Insured (₹) India:	XXXXXXXXXXXX	XXXXXXXXXXXX	XXXXXXXXXXXX	XXXXXXXXXXXX
Cumulative Bonus, If Any	XXXXXXXXXXXX	XXXXXXXXXXXX	XXXXXXXXXXXX	XXXXXXXXXXXX
Type Of Cover:	Individual Floater	Individual Floater	Individual Floater	Individual Floater
Details	Member 5	Member 6	Member 7	Member 8
Name Of Insurer:	XXXXXXXXXXXX	XXXXXXXXXXXX	XXXXXXXXXXXX	XXXXXXXXXXXX
Policy No.	XXXXXXXXXXXX	XXXXXXXXXXXX	XXXXXXXXXXXX	XXXXXXXXXXXX
Policy: From	DD/MM/YYYY	DD/MM/YYYY	DD/MM/YYYY	DD/MM/YYYY
Period: To	DD/MM/YYYY	DD/MM/YYYY	DD/MM/YYYY	DD/MM/YYYY
Date Of First Enrollment:	DD/MM/YYYY	DD/MM/YYYY	DD/MM/YYYY	DD/MM/YYYY
Geography Of Coverage ('Abroad' Shall Exclude Travel Insurance)	India Abroad India and Abroad	India Abroad India and Abroad	India Abroad India and Abroad	India Abroad India and Abroad
Is USA and Canada Covered?	Yes / No	Yes / No	Yes / No	Yes / No
Sum Insured Global (If Applicable):	Currency_____ SI_____	Currency_____ SI_____	Currency_____ SI_____	Currency_____ SI_____
Sum Insured (₹) India:	XXXXXXXXXXXX	XXXXXXXXXXXX	XXXXXXXXXXXX	XXXXXXXXXXXX
Cumulative Bonus, If Any	XXXXXXXXXXXX	XXXXXXXXXXXX	XXXXXXXXXXXX	XXXXXXXXXXXX
Type Of Cover:	Individual Floater	Individual Floater	Individual Floater	Individual Floater

Are You Applying For Portability Of The Above Policy? Yes / No (If Yes, Please Fill In The Separate Portability Form).



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PREMIUM PAYMENT DETAILS

Payment Frequency: Lumpsum / 3 EMIs / 6 EMIs / 9 EMIs
(EMI: Equated Monthly Installments)

Payment By: Cheque / DD / Credit Card / Debit Card / NEFT/ Net Banking

Amount In Figures: ₹ _____ Cheque/DD Date DD / MM / YYYY

Amount In Words:

Cheque/DD/Card No:

Bank Name:

Name Of Premium Payer:

Note - In case the payment is made through Cheque/DD then please issue an a/c payee instrument in favour of "IndusInd General Insurance Company Limited"

In case the payment is made through Credit/Debit Card the Card needs to be in the name of Proposer

Activate Auto-debit for easy premium payment

(Please fill the attached Mandate Form for Auto-pay (NACH / ECS / Direct Debit) form for instalment/renewal premium payment through standing instruction)

STANDARD DECLARATIONS & WARRANTY ON BEHALF OF ALL PERSONS PROPOSED TO BE INSURED

- 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/ 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 insurer and that the policy will come into force only after full payment of the premium chargeable.
- 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 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 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.

OTHER DECLARATIONS & WARRANTY ON BEHALF OF ALL PERSONS PROPOSED TO BE INSURED

- I consent to receive information from the Company through physical, electronic or telecommunication means from time to time
- I hereby state that the above-mentioned address shall be taken as address on record for the purpose of GST.
- I hereby confirm that the contents of the proposal form and connected documents have been fully explained to me/us and I have fully understood the significance of the proposed contract.
- I understand that the Policy shall become void at the Company's option, in the event of misrepresentation, mis-description or non-disclosure of any material fact in the Proposal form/personal statement, declaration and connected documents or any material information having been withheld by me or anyone acting on my behalf.
- I hereby declare that the person(s) proposed to be insured would submit to medical examinations, before the nominated doctors of the Company, or undergo diagnostic or other medical tests, as suggested by the Company for its underwriting.
- I consent to provide a valid age proof and identity proof at the time of claims or any other time when required by the Company.
- 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.
- I authorize the Company to auto renew the policy issued against this proposal form for ___ years. I understand and agree that the renewal would be effective subject to receipt of applicable premium before the due date. The premium applicable would be as per age and premium rates on the due date of renewal
- I hereby permit/authorise IndusInd General Insurance Company Limited to collect, store, communicate and process information relating to the Policy(ies) and all transactions related therewith, including sharing and disclosing to public authorities, of any confidential information as required by law and to send me information in relation to the Policy and General Insurance products & services, irrespective of whether I am registered with the National Customer Preference Register (NCPRI) [formerly the National Do Not Call Registry (NDNC)] or not.

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- To protect the environment and save paper, I hereby give my consent to IndusInd General Insurance Company Limited to send me the executed Policy copy and all related documents and other communications in electronic form by way of email to the aforesaid email id instead of physical form and also to share all such documents and any updates & alerts via Whatsapp on my registered mobile number with the Company
- To protect the environment and save paper, I hereby give my consent to IndusInd General Insurance Company Limited to send me the executed Policy copy and all related documents and other communications in electronic form by way of email to the aforesaid email id instead of physical form and also to share all such documents and any updates & alerts via Whatsapp on my registered mobile number with the Company
- I hereby authorise IndusInd General Insurance Company Limited to collect, store and share the information provided by me for the purposes as detailed under the IndusInd General Insurance Company Limited Privacy Policy [Link to the policy] and the Terms of Use [Link to terms of use] which I acknowledge to have been read and understood by me and shall be bound by the same, subject to the understanding that use and transmission of such personal information shall be done in a secure and confidential manner and that I shall have the right to withdraw such consent at any given time by intimating as such to IndusInd General Insurance Company Limited.
- I hereby declare and confirm that the person(s) proposed to be Insured are Indian Citizen and residing in India for continuous more than 6 months / are not NRI / OCI / Ex. pat.

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".

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 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 offense listed in Prevention of Money Laundering Act,2002.
- I understand that the Company has the right to call for document to established sources of funds.
- The Insurance Company has right to cancel the insurance contract in case I am/have been found guilty by competent court of law under any of the statutes, directly or indirectly governing the prevention of money laundering in India.

PROPOSER'S SIGNATURE *	Date	Place	Time
Verified by providing OTP number sent to registered mobile no. (9xxxxxxx33) at (HH:MM:SS) on DD-MM-YYYY and confirmed at (HH:MM:SS) on DD-MM-YYYY			



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*Signature authentication: A One Time Password (OTP) authentication number has been sent on. Your registered mobile number. By feeding in the said OTP number in the system, You hereby unconditionally and absolutely acknowledge and accept the declarations as stated above in its entirety, and the same would create a legally binding agreement between You and the Company.

AGENT / INTERMEDIARY'S DECLARATION [IN CASE BUSINESS IS SOURCED THROUGH AN AGENT / INTERMEDIARY]

[Agent / Intermediary confirmed using a tick box provided for recording following consent].

I, (Full Name) _____ in my capacity as an Insurance Advisor/ Specified Person of the Corporate Agent/Insurance Web Aggregator/Authorized employee of the Broker/Relationship Officer, do hereby declare that I have explained all the contents of this Proposal Form, including the nature of the questions contained in this Proposal Form to the Proposer including statement(s), information and response(s) submitted by him/her in this Proposal Form to questions contained herein or any details sought herein will form the basis of the Contract of Insurance between IndusInd General Insurance Company Limited and the Proposer, if this Proposal is accepted by IndusInd General Insurance Company Limited for issuance of the Policy. I have further explained that if any untrue statement(s)/ information/response(s) is/are contained in this Proposal Form/including addendum(s), affidavits, statements, submissions, furnished/to be furnished and furthermore if there has been a non-disclosure of any material fact, the policy issued to his/her favor pursuant to this Proposal may be treated by IndusInd General Insurance Company Limited as null and void and all premiums paid under the Policy may be forfeited to IndusInd General Insurance Company Limited. The content of this form and its particulars have been explained by me in vernacular to the proposer who has understood and confirmed the same. I confirm that to the best of my knowledge all the material facts about the prospect and the insured relevant to insurance underwriting, including any adverse habits or income inconsistency has been disclosed herewith.

Agent / Intermediary Name _____

Agent / Intermediary Code _____

License No. _____

Place: _____

Date: D D / M M / Y Y Y Y _____

[Display 'Confirmed' when ticked]

Signature of Agent / Intermediary _____

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

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 insurers
2. Any person making default in complying with the provision of this section shall be liable for a penalty which may extend to ten lakh rupees.

ACKNOWLEDGEMENT FOR PROPOSAL

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

Date: D D / M M / Y Y Y Y _____

Proposal No. _____

We acknowledge the receipt of payment of Rs _____ vide cheque / DD no. _____

from Mr./Mrs./Ms. _____

Please note that this is only an acknowledgement 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 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 Employee _____

Company Seal and Stamp _____



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CUSTOMER INFORMATION SHEET (DESCRIPTION IS ILLUSTRATIVE AND NOT EXHAUSTIVE)

SI NO	TITLE	DESCRIPTION	REFER TO POLICY CLAUSE NUMBER
1.	Product name	IndusInd Health Global	
2.	What am I covered for:	Global Cover (Applicable outside India)	3.1
		a. In-Patient Treatment - This benefit indemnifies the Insured Person for the medical expenses incurred on In-Patient Treatment outside India	3.1.1
		b. Pre and Post-Operative Day Care Treatment - This benefit indemnifies the Insured Person for the medical expenses incurred on pre or post-Operative Day Care Treatment in connection with the In-Patient Treatment	3.1.2
		c. Pre Hospitalization - This cover indemnifies the Insured Person for Pre-hospitalization for a period of 15 days or to the date of start of pre-approved In-Patient Treatment whichever is earlier	3.1.3
		d. Post Hospitalization - This cover indemnifies the Insured Person for Post-hospitalization for a period of 30 days immediately after the Insured Person was discharged from Hospital after taking the In-Patient Treatment	3.1.4
		e. Rehabilitation - This cover indemnifies towards In-patient Rehabilitation treatment Abroad that combines therapies such as physical, occupational and speech therapy	3.1.5
		f. Travel Expenses - This cover indemnifies towards travel expenses incurred by the Insured Person, one accompanying Companion and the living donor (only in the case of transplant) for the treatment of Insured Person	3.1.6
		g. Accommodation Expenses - This cover indemnifies towards accommodation expenses incurred in the City of Treatment by the Insured Person, one accompanying companion and the living donor.	3.1.7
		h. Repatriation of Mortal Remains - In the event of the death of the Insured Person while taking treatment Abroad, covers cost of transporting mortal remains of Insured Person back to the Republic of India or an equivalent amount for a local burial or cremation in the City of Treatment.	3.1.8
		i. Second Opinion - This benefit indemnifies for availing second medical opinion of the listed Specified Illness from a Medical Practitioner.	3.1.9
		j. Visa Charges and Documentation - This cover indemnifies towards Visa application and processing fee expenses incurred by Insured for overseas travel for the purpose of availing the treatment.	3.1.10
		k. Assistance Services - Covers following assistance services rendered by the Insured Person in the event of Emergency.	3.1.11
		• Translation services	3.1.11.1
		• Transmission of urgent messages	3.1.11.2
		• Lost Passport Assistance	3.1.11.3
		• Consular Referral	3.1.11.4
		• Arrangement of Radio Taxi or Chauffeur services	3.1.11.5
		• Emergency cash assistance	3.1.11.6
		India Cover (Optional)	3.2
		a. In-Patient Treatment - This benefit indemnifies the Insured for the medical expenses on In-Patient Treatment in India	3.2.1.1
		b. Day Care Treatment - This benefit indemnifies the Insured for the medical expenses on Day Care Treatment	3.2.1.2



c.	Domestic Road Ambulance - This benefit indemnifies the Insured Person towards expenses incurred on availing Road Ambulance services	3.2.2
d.	Air Ambulance - This benefit indemnifies the Insured Person towards expenses incurred on availing Air Ambulance services	3.2.3
e.	Domiciliary Hospitalization - This cover pays reasonable and customary charges for the medical expenses incurred during Domiciliary Hospitalization as defined under this Policy, provided that the condition for which the medical treatment is required continues for at least three continuous and completed days	3.2.4
f.	Modern Treatment - This cover indemnifies the medical expenses incurred during the Policy Year on Inpatient Treatment or Daycare Treatment or Domiciliary Treatment of listed Modern Treatment Methods	3.2.5
g.	Pre-Hospitalization - This cover indemnifies the Insured Person for Pre-Hospitalization Expenses for a period of 90 days immediately before the Insured Person was Hospitalized	3.2.6
h.	Post-Hospitalization - This cover indemnifies the Insured Person for Post-Hospitalization Expenses for a period of 180 days immediately after the Insured Person was discharged post Hospitalization	3.2.7
i.	Organ Donor Expenses - This cover indemnifies towards medical expenses incurred, during In Patient Treatment, in respect of donor of any organ transplant surgery	3.2.8
j.	Rehabilitation - This cover indemnifies towards In-patient Rehabilitation treatment that combines therapies such as physical, occupational and speech therapy	3.2.9
k.	Home Care Treatment - This cover indemnifies towards Home Care Treatment of any of the listed treatments	3.2.10
l.	Medical Equipment - Cover expenses incurred by the insured person for procuring listed medical equipment or devices as medical aid during the policy year	3.2.11
	• Durable Medical Equipment (DME)	3.2.11.1
	• Small Medical Equipment	3.2.11.2
m.	OPD Covers - Coverage for Out-patient Treatment, Physiotherapy Benefit and Dental Cover	3.2.12
n.	Health Check Up - At the end of every two Policy Year, this benefit indemnifies up to Rs.10000 towards expenses for the listed diagnostic or preventive medical tests (listed in Policy wordings) taken by the Insured Persons in the Policy.	3.2.13
o.	Second Opinion - This benefit indemnifies for availing second medical opinion from a Medical Practitioner within India.	3.2.14
p.	No Claim Bonus - This renewal benefit increases the Sum Insured by 25% for every claim free Policy Year, subject to a maximum of 100% of Sum Insured and decreases by 25 % of Sum Insured for every claim year.	3.2.15
q.	Inflation Protection - This renewal benefit increases the Sum Insured by 8% at the end of each completed and continuous Policy Year, subject to a maximum of 100% of Sum Insured	3.2.16
r.	Unlimited Reinstatement - Unlimited reinstatement of India Base Sum Insured on related or unrelated illness or injury	3.2.17
s.	Assistance Services - Covers following assistance services rendered by the Insured Person in the event of Emergency	3.2.18
	• Tele-consultation	3.1.18.1
	• Booking of health checkups	3.1.18.2
	• Arrangement of Nurse at home	3.1.18.3
	• Emergency helpline	3.1.18.4
	Optional Covers	3.3
a.	Waiver of Co-Payment - This benefit waives off the Co-Payment condition of 20% on the Assessed Claim Amount, applicable on Policies where the Insured age, first time entering into the Policy is >=61 years.	3.3.1
b.	Voluntary Co-payment - 10%/20% on the Assessed Claim Amount	3.3.2



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		c. Change in Pre-Existing Waiting Period - This benefit changes the Pre-Existing Waiting Period from 36 months to 12 or 24 months.	3.3.3
3.	What are the major exclusion in the policy:	<p>Following is a partial list of the policy exclusions. Please refer to the policy document for the complete list of exclusions:</p> <ul style="list-style-type: none"> a. Investigation & Evaluation (Code:Excl04) b. Rest Cure, rehabilitation and respite care (Code:Excl05) c. Obesity/ Weight Control (Code:Excl06) d. Change-of-Gender treatments (Code:Excl07) e. Cosmetic or Plastic Surgery (Code: Excl08) f. Hazardous or Adventure sports(Code:Excl09) g. Breach of law (Code: Excl10) h. Excluded Providers (Code:Excl11) i. Substance Abuse and Alcohol (Code: Excl12) j. Wellness and Rejuvenation (Code:Excl13) k. Dietary Supplements & Substances (Code: Excl14) l. Refractive Error (Code: Excl15) m. Unproven Treatments-Code (Code: Excl16) n. Sterility and Infertility (Code: Excl17) o. Maternity Expenses (Code - Excl 18) 	4.1
		<p>Specific Exclusions (Applicable-to both Global and India)</p> <ul style="list-style-type: none"> a. Organ Donor Expenses b. Treatment outside Discipline c. Gene Therapy except to the extent specifically stated to be covered d. Hearing Aids and spectacles e. External durable medical equipment f. Sleep Apnea g. External Congenital Anomaly h. Artificial Life support equipment's i. Outpatient Treatment expect to the specifically stated to be covered j. Self-injury k. Documentation charges l. Circumcision m. Convalescence or Rehabilitation expect to the specifically stated to be covered n. Dental Treatments expect to the specifically stated to be covered o. Unprescribed Drugs or treatments p. Hormonal therapies q. Peritoneal dialysis r. Non-Medically Necessary Treatment s. Spinal subluxation, manipulation and muscle stimulation t. Treatment by a family member u. Vaccination and immunization v. Charges other than Reasonable & Customary Charges w. Nuclear Attack x. War 	4.2
		<p>Specific Exclusions (Applicable- Global)</p> <ul style="list-style-type: none"> a. Alternative Treatments b. Countries outside Geographical Scope c. Non-payable items d. Sanction Clause e. Treatment taken in India 	4.3



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		Specific Exclusions (Applicable- India) a. Medical supplies b. Prosthetic and other devices c. Treatment taken Abroad d. RMO charges and Service charge	4.4
4.	Waiting Periods	Applicable for Global Cover: a. Pre-Existing Disease waiting period (Code: Excl01): 36 months b. Specified disease/procedure (Code: Excl02) • 36 months for Joint Replacement/Reconstruction (Hip, Knee, Shoulder) • 36 months for Gene therapy • 24 months for listed illnesses/procedures c. 90 days initial Waiting Period	4.1.1 4.1.2 4.3.1
		Applicable for India Cover (if opted): a. Pre-Existing Disease waiting period (Code: Excl01): 36 months b. Specified disease/procedure (Code: Excl02) • 24 months for Joint Replacement/Reconstruction (Hip, Knee, Shoulder) • 36 months for Gene therapy • 24 months for listed illnesses/procedures c. 30 days initial Waiting Period d. Dental Cover: 30 days	4.1.1 4.1.2 4.4.1 3.2.12.4
5.	Payment Basis	Payment on indemnity basis for all covers except OPD cover, Health Checkup and Assistance Service which are on Benefit basis	
6.	Loss Sharing	Co-Payment 20% co-payment on the Assessed Claim Amount if at the time of inception of the first Policy with the Company, the age of the Insured Person is 61 years and above.	6.13
7.	Renewal Conditions	The policy shall ordinarily be renewable except on grounds of fraud, moral hazard, misrepresentation by the insured person. Renewal shall not be denied on the ground that the insured had made a claim or claims in the preceding policy years.	5.1.8
8.	Cancellation	a. The Policyholder may cancel this Policy by giving 15 days' written notice, and in such an event, the Company shall refund premium on short term rates for the unexpired Policy Period as per the rates detailed in the policy terms and conditions. b. The Company may cancel the policy at any time on grounds of misrepresentation, non-disclosure of material facts, fraud by the Insured Person by giving 15 days' written notice.	5.1.7
9.	Claims	Claims Procedure (Applicable Global) Cashless: Claims shall be settled on cashless basis. Insured may contact the Empaneled Service Provider with a request for claim. Details of the Empaneled Service Provider shall be available on the Company website. On the basis of documents submitted and Insured Person's medical condition the Empaneled Service Provider provide a choice of Hospitals/treatments to the Insured Person. Re-imbursment: In case of any Claim under the Benefits Pre-Hospitalization, Post- Hospitalization, Visa Charges and Documentation and Assistance Services where Cashless facility is not availed, Insured can avail the claim under Re-imbursment basis	6.3(i) 6.3(ii)
		Claims Procedure (Applicable India) Cashless: The Insured Person can avail Cashless facility at the time of admission into any Network Hospital, by presenting the health card as provided by the TPA/Company with the Policy, along with a valid photo identification proof (Voter ID card / Driving License / Passport / PAN Card / any other identity proof as approved by the Company). Re-imbursment: In case of any Claim under the Benefits, where Cashless facility is not availed, the list of documents as mentioned in Policy Wording shall be provided by the Policyholder/ Insured Person, immediately but not later than 15 days of discharge from the Hospital, at the Policyholder's/ Insured Person's expense to avail the Claim.	6.4(i) 6.4(ii)



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10.	Policy Servicing	Any issues related with respect to policy, kindly E-mail us at services@indusindinsurance.com and for correspondence contact us IndusInd General Insurance Company Limited Correspondence Address – IndusInd General Insurance, Winway Building, 2nd & 3rd Floor, 11/12 Block No. 4, Old No. 67, South Tukoganj, Indore (M.P) - 452001. Contact No.: 022 - 41112600	
11.	Grievances/ Complaints	a. Details of Grievance redressal officer refer the link (https://www.indusindinsurance.com/Insurance/About-Us/Grievance-Redressal.aspx) b. IRDAI Integrated Grievance Management System- https://igms.irda.gov.in/ c. Insurance Ombudsman - The contact details of the Insurance Ombudsman offices have been provided as Annexure-B of Policy document	5.1.15
12.	Insured's Rights	a. Free Look period of 15 days from the date of receipt of the policy shall be applicable at the inception. b. Lifelong renewability (except on certain specific grounds) c. Right to migrate from one product to another product of the company (E-mail us at services@indusindinsurance.com and For correspondence contact us IndusInd General Insurance, Winway Building, 2nd & 3rd Floor, 11/12 Block No. 4, Old No. 67, South Tukoganj, Indore (M.P) - 452001. Contact No.: 022 - 41112600 d. Right to port the from one company to another company (E-mail us at services@indusindinsurance.com and For correspondence contact us IndusInd General Insurance, Winway Building, 2nd & 3rd Floor, 11/12 Block No. 4, Old No. 67, South Tukoganj, Indore (M.P) - 452001. e. Change in SI during the policy term or at the time of renewal E-mail us at services@indusindinsurance.com	5.1.13 5.1.8 5.1.16 5.1.17 5.2.6
13.	Insured's Obligations	Please disclose all pre-existing disease/s or condition/s before buying a policy. Non-disclosure may result in claim not being paid.	5.2.4

Legal Disclaimer Note: The information must be read in conjunction with the product brochure and policy document. In case of any conflict between the CIS and the policy document, the terms and conditions mentioned in the policy document shall prevail.

Premium Illustration attached to CIS

Benefit Illustration in respect of policies offered on Individual and Family Floater basis

Age of the members insured	Coverage opted on individual basis covering each member of the family separately (at a single point in time)		Coverage opted on individual basis covering multiple members of the family under a single policy (Sum insured is available for each member of the family)				Coverage opted on family floater basis with overall Sum insured (Only one sum insured is available for the entire family)			
	Premium (Rs.)	Sum insured (USD)	Premium (Rs.)	Discount, if any	Premium after discount (Rs.)	Sum insured (USD)	Premium or consolidated premium for all members of family (Rs.)	Floater discount, if any	Premium after discount (Rs.)	Sum insured (USD)
51 years	20,470	150,000	20,470		18,423	150,000	20,470			
44 years	12,234	150,000	12,234	10%	11,011	150,000	12,234	30%	36,411	150,000
23 years	9,721	150,000	9,721		8,749	150,000	9,721			
18 years	9,590	150,000	9,590		8,631	150,000	9,590			
Total Premium for all members of the family is Rs. 52,015 when each member is covered separately.			Total Premium for all members of the family is Rs. 46,814 when they are covered under a single policy.				Total Premium when policy is opted on floater basis is Rs. 36,411			
Sum insured available for each individual is USD 1.5 lakh			Sum insured available for each family member is USD 1.5 lakh				Sum insured of USD 1.5 lakh is available for the entire family.			

Note: Premium rates specified in the above illustration are standard premium rates for Elite Plan with Worldwide coverage. The rates are without any optional covers, loading and discounts and are exclusive of taxes applicable.

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