IndusInd GENERAL INSURANCE
FORMERLY RELIANCE GENERAL INSURANCE

INDUSIND HEALTH INFINITY INSURANCE - 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		
Intermediary Name		Code
Branch Name		Code
Sales Manager Name		Code
PROPOSER DETAILS		
Name		
Date of birth (DD.MM.YYYY)		Nationality
Mobile No.:		Email
Alternative Mobile No.		Alternative Email
Occupation		Annual Income
Pan No.:		(Mandatory) If not provided Form 60 required.)
CKYC No.:		(for Individual customer)
Gender: ☐ Male	☐ Female	☐ Other
Marital Status: ☐ Married	☐ Single	☐ Other
Current Address		
City	State	Pincode
Avail for Zone B discount?		
☐ Yes: Discount of 20% shall apply. Copay of 20% shall apply if treatment is taken in Zone A: Delhi, New Delhi & NCR including Faridabad, Noida, Ghaziabad, Gurugram, Noida, Gautam Buddha Nagar, Mumbai & Suburbs, MMR (Mumbai Metropolitan Region), Navi Mumbai & Suburbs, Thane City & Suburbs, Mira Road, Bhayandar, Panvel, Kalyan & Dombivali, State of Gujarat, Kolkata & Suburbs.		
☐ No		
Permanent address		
City	State	Pincode
PROPOSER'S BANK DETAILS		
Name of the Bank Account Holder:		
Bank Account No.		Account Type: ☐ Saving ☐ Current
Bank Name:		Branch name:
MICR Code (9 digit code appearing on the cheque issued by the bank):		
IFSC Code (11 character code appearing on your cheque leaf)		

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 Health Infinity Insurance. UIN: RELHLIP23120V042223. IGI/MCOM/CO/HI/PF1/VER.1.0/160924.

☐ 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.

OTHER DETAILS

GSTIN (if any):

Do you have an e-Insurance Account (e-IA)? ☐ Yes ☐ No

☐ If 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"

☐ If Yes, e-Insurance Account (eIA) No.

IndusInd General Insurance Company Limited Existing Retail Policy No (if applicable):

IndusInd Group Employee Number and Name (if applicable):

IndusInd Group Shareholder (1) Folio Number or (2) DP Id & Client Id No. (if applicable):

☐ I would like to share my Consumer Credit Information with IndusInd General Insurance for evaluation of additional discount on my policy. (If Yes, please sign the consent form attached)

☐ No, I would not like additional discount on my policy

PREMIUM DETAILS

Payment frequency: ☐ Lumpsum ☐ Half-yearly ☐ Quarterly ☐ Monthly

Payment by: ☐ Cheque ☐ DD ☐ Credit Card ☐ Debit Card ☐ NEFT ☐ Net Banking

Payer Name:	Bank Name:
Cheque/DD/Card Number:	Cheque/DD Date:

Amount in figures (Rs.): _____

Amount in words: _____

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

PRODUCT DETAILS (Tick / Fill the required option) (All fields are mandatory)

Cover Type	☐ Individual ☐ Floater
Sum Insured (Rs)	☐ 3lakhs ☐ 5lakhs ☐ 10lakhs ☐ 15lakhs ☐ 25lakhs ☐ 50lakhs ☐ 100lakhs ☐ 200lakhs ☐ 300lakhs ☐ 400lakhs ☐ 500lakhs
Policy Term	☐ 1 Year ☐ 2 Years ☐ 3 Years
More Options Benefit(s) opted*	☐ MoreTime ☐ MoreCover ☐ MoreGlobal ☐ None • One 'More Option' is complementary • Additional premium chargeable for more than one 'More Option' • Discount applicable if 'None' is opted

Add On Covers (Tick the required option)

Limitless Cover: Consumables Covers, Unlimited Restore Benefit	☐ Yes ☐ No
Smart Protector: Super Charger, Air Ambulance	☐ Yes ☐ No If Yes, limit required for Super Charger ☐ Option 1: 20% of S.I, maximum up to 100% of S.I ☐ Option 2: 33.33% of S.I, maximum up to 100% of S.I

Mother and Child Care: Maternity Cover, New-born Baby and Vaccination Cover	☐ Yes ☐ No If Yes, choose the Maternity limit: ☐ 1 lakh ☐ 2lakhs (Note: 2 lakhs option not available for Sum Insured 5 lakhs) Maternity Waiting Period required: ☐ 12 months ☐ 24 months
Limitless Cover: Consumables Covers, Unlimited Restore Benefit	☐ Yes ☐ No If yes, Choose any one limit: Plan A: OPD Limit: ☐ 10000 ☐ 15000 ☐ 20000 Plan B: OPD Limit: ☐ 25000 ☐ 30000 ☐ 35000 ☐ 40000 ☐ 45000 ☐ 50000
Medical Equipment Cover	☐ Yes ☐ No
Double Cover	☐ Yes ☐ No
Home Care Treatment	☐ Yes ☐ No
Change in Pre-Existing Waiting Period	☐ Yes ☐ No, keep it 36 months If Yes, choose the required option: ☐ 24 months ☐ 12 months
Reduction in Specific Waiting Period	☐ Yes, to 12 months ☐ No, keep it 24 months
Reduction in Room Rent	☐ Yes ☐ No If Yes, choose one: ☐ Single Private A.C Room ☐ Twin Sharing
Voluntary Copayment	☐ Yes 10% ☐ No
Voluntary Aggregate Deductible	☐ None ☐ 10000 ☐ 25000 ☐ 50000 ☐ 100000

Note: OPD Cover can be purchased for Insured Persons up to age 60 years (for floater policies, age of the eldest member shall be considered).

Existing Health Insurance Details

Details	**Person 1**	**Person 2**	**Person 3**	**Person 4**	**Person 5**	**Person 6**	**Person 7**	**Person 8**
Name of Insurer								
Policy no.								
Policy Period – From: (DD/MM/YYYY)								
Policy Period – To: (DD/MM/YYYY)								
Sum Insured (Rs.)								
Cumulative Bonus, if any								
Type of Cover	☐ Individual ☐ Floater	☐ Individual ☐ Floater	☐ Individual ☐ Floater	☐ Individual ☐ Floater	☐ Individual ☐ Floater	☐ Individual ☐ Floater	☐ Individual ☐ Floater	☐ Individual ☐ Floater
Have any of the persons to be insured ever filed a claim with their current/previous insurer? If yes, please provide details on a separate sheet	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N
Has any proposal of life, critical or health insurance been declined, cancelled or charged a higher premium?	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N

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 Health Infinity Insurance. UIN: RELHLIP23120V042223. IGI/MCOM/CO/HI/PF1/VER.1.0/160924.

Are any of the persons proposed for insurance covered under any other health insurance policy with the Company?	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N

Are you applying for portability of the above policy? ☐ Y / ☐ N (If yes, please fill in the separate Portability Form).

If you choose 'No' and continue the above existing policy along with IndusInd Health Infinity Insurance, the proposal shall be eligible to get a concurrent policy discount on premium

NOMINATION DETAILS

In the event of the death of an Insured Person any payment due under the Policy shall become payable to the Nominee in accordance with the Policy terms and conditions. The Nominee must be an immediate relative of the Proposer. Nominee for any of the persons proposed to be insured shall be the Proposer.

Name	Mobile No.	Email	Date of Birth	Relationship with proposer

If the Nominee is minor, name and address of Appointee and Relationship with Minor:

Name	Mobile No.	Email	Date of Birth	Relationship with proposer

DETAILS OF THE PERSON(S) PROPOSED TO BE INSURED

Section A : Personal Details

Details	**Person 1**	**Person 2**	**Person 3**	**Person 4**	**Person 5**	**Person 6**	**Person 7**	**Person 8**
Name of Insured Person								
Gender(M/F)								
Date of Birth								
Relationship with Proposer								
Mobile								
Email								
Nationality								
Occupation								
Height (in cms.)								
Weight (in kgs.)								
Blood Group								
Aadhaar Number/Virtual ID (last four digit)								
Annual Income								

Medical Questions	**Person 1**	**Person 2**	**Person 3**	**Person 4**	**Person 5**	**Person 6**	**Person 7**	**Person 8**
The following Medical questions are compulsory for each proposal. Where any of the below responses are positive (Yes), the list of PED questions shall be triggered.								
Is any person proposed to be insured on (or prescribed to be on) regular medication (Medication prescribed for more than two weeks)?	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N

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?	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N
Is any person proposed to be insured been advised to undergo any investigation or further tests other than routine health check-up or pre-employment check-up or routine maternity checkup in last 3 years?	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N
Has any person proposed to be insured, undergone any surgery in the last 3 years or is planned to undergo any surgery at present or in the near future?	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N
Was any person proposed to be insured diagnosed with any of these medical conditions with or without any follow-up tests/medications?								
• Diabetes	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N
• Hypertension	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N
• High Cholesterol or high triglycerides	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N
• Hypothyroidism or Pituitary disorder	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N
• Liver Cirrhosis	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N
• HIV/AIDS	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N
• Unexplained Weight loss (> 5kg) in last 6 months	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N
Is any of the Insured Person Pregnant? If yes, please mention the date of delivery.	☐ Y / ☐ N Date of Delivery - dd/mm/yyyy	☐ Y / ☐ N Date of Delivery - dd/mm/yyyy	☐ Y / ☐ N Date of Delivery - dd/mm/yyyy	☐ Y / ☐ N Date of Delivery - dd/mm/yyyy	☐ Y / ☐ N Date of Delivery - dd/mm/yyyy	☐ Y / ☐ N Date of Delivery - dd/mm/yyyy	☐ Y / ☐ N Date of Delivery - dd/mm/yyyy	☐ Y / ☐ N Date of Delivery - dd/mm/yyyy
Has any application for health (or Mediclaim),hospital daily cash or critical illness insurance for any person proposed to be insured ever been:								
• Declined	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N
• Subject to Loading in premium due to health conditions or been made	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N
• Subject to any special conditions by any insurance company	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N

PED Questions	**Person 1**	**Person 2**	**Person 3**	**Person 4**	**Person 5**	**Person 6**	**Person 7**	**Person 8**
Has the person proposed to be insured suffered from (or undergone) any of the following illnesses/sickness/medical conditions/medical procedures during the past 3 years? (Yes/ No, Date of First Diagnosis):								

Chest Pain or Heart Attack or any ailment/ diseases/ surgery of the Heart or arteries or other blood vessels?	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N
Lung transplant, Chronic Obstructive Pulmonary Disease, Obstructive Sleep Apnea, Pulmonary Fibrosis, Tuberculosis, Asthma, Bronchitis, breathing difficulties or disorder of the lung/ respiratory track requiring surgery or hospitalization within the past 3 years?	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N
Any sexually transmitted diseases including Syphilis, Gonorrhoea, Genital Herpes, Chlamydia?	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N
Liver Cirrhosis, Alcoholic Liver disease, Esophageal Varises and Fibrosis, Pancreatic Disease, Hepatitis B, Hepatitis C or any other disorder of the liver or pancreas, or Liver transplant?	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N
Inflammatory Bowel Disease, Crohn's disease, Systemic Lupus Erythematosus or any other ailment of the digestive system?	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N
Cancer, Leukemia, Papulosquamous disorder of skin, Tumor - malignant, or any growth or cyst anywhere in the body?	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N
Rheumatoid arthritis, Avascular Necrosis, Ankylosing Spondylitis, Spinal Stenosis, Spondylosis, Multiple Sclerosis, Muscular Dystrophy or any other disorder of bone, muscles or joints?	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N
Kidney transplant, Kidney/Renal Failure, Stone in urinary tract, Prostate disorder or any other kidney disorder whether or not requiring dialysis?	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N
Stroke, Epilepsy (fits), Paralysis, Demyelinating disease, Alzheimers Disease, Parkinsons Disease or any other disorder of the brain, spinal cord or nervous system?	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N
Severe Anemia, Hemophilia, Idopathic Thrombocytopenia Purpura, Thalassemia (major), Peripheral Vascular Disease, Deep Vein Thrombosis, Lymphoma or any other blood/ Lymphatic system disease or Sarcoidosis?	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N
Diabetes with HbA1c >= 10 or fasting sugar above 250, Hypertension with three medication or blood pressure above 180/100?	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N

Cerebral Palsy, any internal deformity or sickness from birth/ early childhood?	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N
Loss of Hearing	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N
Diseases of the Ear/Nose/ Throat/Teeth/ Eye (please mention Diopters in case of refractory error)?	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N
Detoxication therapy for alcohol, narcotics, or any other habit-forming drugs?	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N
Nervous, Psychiatric or Mental or sleep disorder	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N
Any other Illness/Injury: Please Specify								
If you have ticked 'Yes' in any of the boxes above, please name the disease/condition here and specify since when are you suffering from such disease/ condition.	1. Name of Disease/ condition 2. Since: dd/mm/yyyy	1. Name of Disease/ condition 2. Since: dd/mm/yyyy	1. Name of Disease/ condition 2. Since: dd/mm/yyyy	1. Name of Disease/ condition 2. Since: dd/mm/yyyy	1. Name of Disease/ condition 2. Since: dd/mm/yyyy	1. Name of Disease/ condition 2. Since: dd/mm/yyyy	1. Name of Disease/ condition 2. Since: dd/mm/yyyy	1. Name of Disease/ condition 2. Since: dd/mm/yyyy
Lifestyle Questions	**Person 1**	**Person 2**	**Person 3**	**Person 4**	**Person 5**	**Person 6**	**Person 7**	**Person 8**
Does any of the persons proposed to be insured use tobacco products/cigarettes or drink alcohol?	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N
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?	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N

Note: The Company may apply a risk loading upto 150% 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.

Attending Physician's Detail

Name of Family Physician: _____

(Title) (First Name) (Last Name)

Contact Number: _____ E-mail ID: _____

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

- ❑ I/We 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/We am/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 full payment 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 by the company.

- ❑ I/We declare and consent to the company seeking medical information from any doctor or hospital who 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 assured / proposer and seeking information from any insurance company to which an application for insurance on the life to be 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.

OTHER DECLARATIONS & AUTHORIZATIONS

- ❑ 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 submit my Aadhaar number or Virtual ID and give my consent for use of my Aadhaar details to authenticate me from UIDAI and link my Aadhar with all the policies of IndusInd General Insurance Company Limited that I am associated with. I hereby warrant and represent that I have been duly authorised to submit the Aadhaar number or Virtual ID of the insured, nominees and appointees (as the case may be), and consent to the linkage of such Aadhaar details with all policies of IndusInd General Insurance Company Limited that they are associated with.
- ❑ 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 (NCPR) [formerly the National Do Not Call Registry (NDNC)] or not.
- ❑ 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.

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.

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 Health Infinity Insurance. UIN: RELHLIP23120V042223. IGI/MCOM/CO/HI/PF1/VER.1.0/160924.

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".

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 offense 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 competent court of law under any of the statutes, directly or indirectly governing the prevention of money laundering in India.

Place: _____

Date: _____ _____

Signature of Proposer

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.

FOR OFFICE USE ONLY

Channel Name	Branch Code	Campaign Code	IndusInd General Insurance SAP Id	SP Code (For Bancassurance Channel)	Customer Relationship Number (For Bancassurance Channel)	Business Type
						Urban/Social/ Rural

ACKNOWLEDGEMENT FOR PROPOSAL

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

Date: DD / MM / YYYY 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 in 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