

INDUSIND HEALTH SURROGATE AND OOCYTE DONOR RIDER - 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	
IMD Branch Name		Code	
Reference details			
INDUSIND Employee Name		Code	
Base Policy Details			
Base Product Name			
Base Policy Number/ Proposal Number			
Insured Details (Surrogate Mother/Oocyte Donor) (All the details are mandatory)			
Name of Insured	<input type="radio"/> Mr. <input type="radio"/> Ms. <input type="radio"/> Mrs. F I R S T M I D D L E L A S T		
Communication Address:			
City:		State:	
Pin code:			
Contact Number - Primary No.		Secondary No.	
E-mail Id			
Date of Birth	(DD.MM.YYYY)	Nationality	
Gender	<input type="radio"/> Male <input type="radio"/> Female		
Relationship with Intending Couple			
Marital Status	<input type="radio"/> Married <input type="radio"/> Single <input type="radio"/> Other		
Maiden Name			
Occupation	<input type="radio"/> Salaried <input type="radio"/> Self-Employed <input type="radio"/> Others, pls specify _____		
Monthly Income	<input type="radio"/> Upto ₹20,000 <input type="radio"/> ₹20,001 to ₹50,000 <input type="radio"/> ₹50,001 to ₹1,00,000 <input type="radio"/> ₹1,00,001 and above		
Source of Funds	<input type="radio"/> Business <input type="radio"/> Profession <input type="radio"/> Salary <input type="radio"/> Agricultural Income <input type="radio"/> Savings <input type="radio"/> Others		
ABHA Number# OR ABHA ID			
Pan No.: (Form 60 is mandatory if PAN is not provided)		Aadhar No.: (Please fill at least one)	



[indusindinsurance.com](https://www.indusindinsurance.com)



022 4890 3009 (Paid)



74004 22200 (WhatsApp)



GST Registration No.: (if applicable)		CKYC No.: (for individual customer)	
Do you have an existing Health Insurance policy with us?	<input type="radio"/> Yes <input type="radio"/> No	Policy No.	
#ABHA (Ayushman Bharat Health Account) number is your 14 digit unique digital health identification number.			
SURROGACY CLINIC/ASSISTED REPRODUCTIVE CLINIC DETAILS			
Name of the clinic			
Registration Number of the clinic			
Certificate Number of the clinic			
Address of the clinic			
Type of Institution	Government / Private		
MEDICAL PRACTITIONER'S DETAIL*			
Name of Medical Practitioner/ embryologist	(Title)	(First Name)	(Last Name)
Contact Number		E-mail ID	
*Note: The registered Medical Practitioner shall not be the insured or insured's close family member.			
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 Insured. The receipt of proceeds by the nominee would be sufficient discharge to the Company.			
Name of Nominee	Date of Birth (DD.MM.YYYY)	Relationship with Insured	Address of Nominee
POLICY DETAILS (Tick the required option) (All fields are mandatory)			
Policy Tenure	<input type="radio"/> 1 year (for Oocyte Donor) <input type="radio"/> 3 years (for Surrogate)		
Sum Insured opted (in lakhs)	<input type="radio"/> 5 <input type="radio"/> 10		
BANK DETAILS OF SURROGATE MOTHER/OOCYTE DONOR			
Name of Bank Account Holder	OMr. Mrs. OMs. F I R S T M I D D L E L A S T		
Bank Name	Account Type:	<input type="radio"/> Saving <input type="radio"/> Current	
Bank Account No.	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="radio"/> I understand that any payment/claims to be directly credited to my aforesaid Bank Account* <input type="radio"/> I understand that any refund due on the premium payment to be directly credited to the Bank Account of the Proposer as declared under the Base Policy* As per IRDAI, its mandatory that all payments made to the insured are only through electronic mode.			



indusindinsurance.com



022 4890 3009 (Paid)



74004 22200 (WhatsApp)



MEDICAL QUESTIONS	SURROGATE MOTHER/ OOCYTE DONOR
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)?	o Yes o No
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?	o Yes o No
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?	o Yes o No
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?	o Yes o No
Was any person proposed to be insured diagnosed with any of these medical conditions with or without any follow-up tests/medications?	
• Diabetes	o Yes o No
• Hypertension	o Yes o No
• High Cholesterol or high triglycerides	o Yes o No
• Hypothyroidism or Pituitary disorder	o Yes o No
• Liver Cirrhosis	o Yes o No
• HIV/AIDS	o Yes o No
• * Unexplained Weight loss (> 5kg) in last 6 months	o Yes o No
Is any of the Insured Person Pregnant? If yes, please mention the date of delivery and declined.	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	o Yes o No
• Subject to Loading in premium due to health conditions or been made	o Yes o No
• Subject to any special conditions by any insurance company	o Yes o No
PED QUESTIONS	SURROGATE MOTHER/ OOCYTE DONOR
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?	o Yes o No
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?	o Yes o No
Any sexually transmitted diseases including Syphilis, Gonorrhoea, Genital Herpes, Chlamydia?	o Yes o No
Liver Cirrhosis, Alcoholic Liver disease, Oesophageal Varises and Fibrosis, Pancreatic Disease, Hepatitis B, Hepatitis C or any other disorder of the liver or pancreas, or Liver transplant?	o Yes o No
Inflammatory Bowel Disease, Crohn's disease, Systemic Lupus Erythematosus or any other ailment of the digestive system?	o Yes o No
Cancer, Leukemia, Papulosquamous disorder of skin, Tumor - malignant, or any growth or cyst anywhere in the body?	o Yes o No



Rheumatoid arthritis, Avascular Necrosis, Ankylosing Spondylitis, Spinal Stenosis, Spondylosis, Multiple Sclerosis, Muscular Dystrophy or any other disorder of bone, muscles or joints?	<input type="radio"/> Yes <input type="radio"/> No
Kidney transplant, Kidney/Renal Failure, Stone in urinary tract, Prostate disorder or any other kidney disorder whether or not requiring dialysis?	<input type="radio"/> Yes <input type="radio"/> No
Stroke, Epilepsy (fits), Paralysis, Demyelinating disease, Alzheimers Disease, Parkinsons Disease or any other disorder of the brain, spinal cord or nervous system?	<input type="radio"/> Yes <input type="radio"/> No
Severe Anemia, Hemophilia, Idopathic Thrombocytopenia Purpura, Thalassemia (major), Peripheral Vascular Disease, Deep Vein Thrombosis, Lymphoma or any other blood/Lymphatic system disease or Sarcoidosis?	<input type="radio"/> Yes <input type="radio"/> No
Diabetes with HoA1c>- 10 or tasting sugar above 250, Hypertension with three medication or blood pressure above 180/100?	<input type="radio"/> Yes <input type="radio"/> No
Cerebral Palsy, any internal deformity or sickness from birth / early childhood?	<input type="radio"/> Yes <input type="radio"/> No
Loss of Hearing	<input type="radio"/> Yes <input type="radio"/> No
Diseases of the Ear/Nose/Throat/Teeth/ Eye (please mention Diopters in case of refractory error)?	<input type="radio"/> Yes <input type="radio"/> No
Detoxication therapy for alcohol, narcotics, or any other habit-forming drugs?	<input type="radio"/> Yes <input type="radio"/> No
Any other Illness/Injury: Please Specify	<input type="radio"/> Yes <input type="radio"/> No
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)
LIFESTYLE QUESTIONS	SURROGATE MOTHER/ OOCYTE DONOR
Does any of the persons proposed to be insured use tobacco products/cigarettes or drink alcohol?	<input type="radio"/> Yes <input type="radio"/> 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?	<input type="radio"/> Yes <input type="radio"/> No
<p>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.</p> <p>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.</p> <p>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 your proposal and refund the amount after deducting cost of medical tests, if any.</p>	
PREMIUM PAYMENT DETAILS	
Payment frequency:	Lumpsum
Payment by:	<input type="radio"/> Cheque <input type="radio"/> DD <input type="radio"/> Credit Card <input type="radio"/> Debit Card <input type="radio"/> NEFT <input type="radio"/> Net Banking
Cheque or DD amount in figures:	₹ _____ Cheque/DD Date: _____ (DD.MM.YYYY)
Cheque or DD 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

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

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.

STANDARD DECLARATIONS & WARRANTY

- i. I hereby declare, that the above statements, answers and / or particulars given by me are true and complete in all respects to the best of my knowledge
- ii. 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.
- iii. 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.



indusindinsurance.com



022 4890 3009 (Paid)



74004 22200 (WhatsApp)



- iv. 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.
- v. 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.

Place: _____

Date: _____

Signature of Proposer

Place: _____

Date: _____

Signature of Insured

OTHER DECLARATIONS & WARRANTY

- i. I consent to receive information from the Company through physical, electronic or telecommunication means from time to time
- ii. I hereby state that the above-mentioned address shall be taken as address on record for the purpose of GST.
- iii. 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.
- iv. 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.
- v. 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.
- vi. 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.
- vii. 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.
- viii. 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.
- ix. 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
- x. 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.

Place: _____

Date: _____

Signature of Proposer

Place: _____

Date: _____

Signature of Insured



indusindinsurance.com



022 4890 3009 (Paid)



74004 22200 (WhatsApp)



VERNACULAR DECLARATION FOR INTERMEDIARY AND PROPOSER

The contents of this Proposal form have been read over and fully explained to me in _____ language. I further confirm and declare that the contents read over and explained to me have been understood by me.

Place: _____

Date: _____

Signature/Thumb impression of (Proposer)

Place: _____

Date: _____

Signature/Thumb impression of (Insured)

Explained By Intermediary (Name): _____

Place: _____

Date: _____

Signature of Intermediary

PROHIBITION OF REBATES – SECTION 41 OF INSURANCE ACT, 1938

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 ₹ 10 lakh.

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 ₹ _____ 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

Signature of Intermediary

PLEASE ATTACH THE BELOW MANDATORY DOCUMENTS ALONG WITH THIS FORM

- Duly signed written informed consent* of Surrogate Mother or Oocyte Donor
- Certificate of medical and psychological fitness for surrogacy or oocyte donation from a registered medical practitioner
- Certificate of a medical indication in favour of either or both members of the intending couple or intending woman necessitating gestational surrogacy or oocyte donation from a District Medical Board



indusindinsurance.com



022 4890 3009 (Paid)



74004 22200 (WhatsApp)



o Screening report and other Medical Reports related to Surrogate Mother or Oocyte Donor

Place: _____

Date: _____

Signature of Proposer

***Note:** Please find the sample “written informed consent form” under Annexure 2 & 3 of “Annexures to Proposal Form”



indusindinsurance.com



022 4890 3009 (Paid)



74004 22200 (WhatsApp)

