

**INDUSIND - GROUP HOSPI CASH INSURANCE (PLAN B) - PROPOSAL FORM**

<b>INTERMEDIARY DETAILS</b> (To be filled in BLOCK LETTERS)			
Intermediary Name		Code	
Branch Name		Code	
Sales Manager Name		Code	
<b>PROPOSER DETAILS (MASTER POLICY HOLDER)</b> (To be filled in BLOCK LETTERS)			
Name of Proposer	<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
CIN Number		GSTIN	
Entity Details		Date of Birth (Mandatory)	DD/MM/YYYY
Mobile No.		Email	
Alternative Mobile No.		Alternative Email	
Communication Address			
Flat/Building		Road/Street / Sector	
Area		Taluka/Village/District/City	
Pin Code		State	
Business of Proposer		Annual Turnover	
PAN No. (Mandatory) If not provided Form 60		UID Aadhaar No.	
Do you have a GST Registration Number	<input type="radio"/> Yes <input type="radio"/> No		
If Yes, please specify			
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		
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		
Name of Contact Person	<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
Proposed no. of lives covered			
Proposed no. of Employees		Proposed no. of lives covered	
CKYC No.			
<b>PREMIUM PAYMENT DETAILS</b>			
Payment by: <input type="radio"/> Cheque* / <input type="radio"/> DD* / <input type="radio"/> Credit Card# / <input type="radio"/> Debit Card# (Tick whichever is applicable)			
Cheque / DD Amount		Amount in words	_____
Bank Name			
Cheque or DD Date	DD/MM/YYYY	Cheque/DD No.	_____

Name of the Premium Payer			
*In case of payment made through Cheque / DD then please issue an A/c payee instrument in favour of "IndusInd General Insurance Company Limited" # In case of payment made through Credit/ Debit Card the Card needs to be in the name of the Proposer. You can easily renew your policy by filling the attached NACH (ECS) mandate form.			
<b>PROPOSER'S BANK DETAILS</b>			
1. Name of the Bank Account Holder	<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	
2. Bank Account No.:		3. Account:	<input type="radio"/> Saving <input type="radio"/> Current
4. Name of the Bank			
5. Branch			
6. MICR Code (9 digit MICR code number of the bank and branch appearing on the cheque issued by the bank)			
7. IFSC Code (11 character code appearing on your cheque leaf)			
<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.			
<b>PREVIOUS INSURANCE DETAILS</b>			
1. The terms proposed are same as per your existing policy?	<input type="radio"/> Yes <input type="radio"/> No		
if yes please provide expiring policy copy along with this proposal form and provide policy no _____			
If no, please list out the additional coverages: _____			
2. Details of previous / expiring insurance policy for last 3 years?	1st Year	2nd Years	3rd Years
No of lives covered at inception			
No. of lives at expiry			
Incurred Claims Paid + O/s (Count & Amount)			
Premium before service tax			
Name of the insurance company			
Name of the TPA			
<b>POLICY DETAILS</b>			
Policy Period	Start Date DD/MM/YYYY End Date DD/MM/YYYY		
Daily Cash Amount (Please specify in Rs)	_____ (Ranging from 500 to 10000)		
Number of Days (Tick the required options)	<input type="radio"/> 30days <input type="radio"/> 60days <input type="radio"/> 90days <input type="radio"/> 180days		
<b>OPTIONAL COVERS (TICK/SPECIFY THE REQUIRED OPTIONS AND LIMITS)</b>			
<b>Covers</b>	<b>Limits</b>		
Convalescence Cover	<input type="radio"/>	_____ (Options- 3 times/5times /10 times of Daily Cash Amount)	
Personal Accident Cover	<input type="radio"/>	_____	



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IRDAI Registration No. 103. IndusInd General Insurance Company Limited.

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: 6<sup>th</sup> Floor, Oberoi Commerz, International Business Park, Oberoi Garden City, Off. Western Express Highway, Goregaon (E), Mumbai-400063. Corporate Identity Number: U66603MH2000PLC128300.

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Accidental Medical Expenses	<input type="radio"/>	20% of Personal Accident Sum Insured or Rs 5 lakhs whichever is minimum
Companion Cover	<input type="radio"/>	Daily Cash Amount *50% *Selected max. no. of days
Maternity Cover	<input type="radio"/>	5 times of Daily Cash Amount or Rs 35000 whichever is less
Time Deductible	<input type="radio"/>	<input type="radio"/> 24 hours <input type="radio"/> 36 hours <input type="radio"/> 72 hours
Waiver of Waiting Period for Pre-Existing Disease	<input type="radio"/>	<input type="radio"/> 0 months <input type="radio"/> 12 months <input type="radio"/> 24 months
Waiting Period for Specified disease/procedure	<input type="radio"/>	Waiting Period for Specified disease/procedure shall reduce to 12 months
Leave Compensation Benefit	<input type="radio"/>	Per Day compensation, equal to 135% of: the daily basic salary before tax or the Daily Cash amount whichever is lower (Maximum of 90 days; Payable on completion of 4 continuous and consecutive days of In-Patient Hospitalization)
Waiver of 30 days Waiting Period	<input type="radio"/>	This Cover waives off the Initial 30 Days Waiting Period Condition
Waiver of Waiting Period for Maternity Cover	<input type="radio"/>	This Cover waives off the 12 months Maternity Cover Waiting Period Condition

#### INSURED DETAILS

Cadre/ Grade/ Sub-group	Name of Insured Persons	Gender	Date of Birth (dd/mm/yyyy)	Age	Relationship with the Primary Insured Person	Employee Id of the Primary Insured Person	DOJ (dd/mm/yyyy)	Grade/ Designation of Primary Insured Person	Date of addition to Policy	Daily Cash Amount	Number of Days	Optional Covers	Specify Optional Cover limits, if any Cadre/ Grade wise selection made	
					Self Spouse Son Daughter Parents Parents in law						In Pati- ent xxx	ICU: xxx	1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11	

#### STANDARD AND SPECIFIC EXCLUSIONS

This is only a brief summary of the exclusions in your policy, for full list of general exclusions please refer to policy terms and conditions: Investigation & Evaluation, Rest Cure, Rehabilitation and Respite care, Obesity/ Weight Control, Change-of-Gender treatments, Cosmetic or Plastic Surgery Hazardous or Adventure sports, Breach of law, Excluded Providers, Drugs or treatments, Wellness and Rejuvenation, Dietary Supplements & Substances, Refractive Error, Unproven Treatments, Sterility and Infertility, Maternity, Dental Treatments, Domiciliary Hospitalization and Home Treatment, External Congenital Anomaly, Treatment other than Medically Necessary Treatment, Non-medical expenses, Nuclear and radiological emissions, acts of terrorism, Outpatient treatment, Overseas treatment, Charges other than Reasonable & Customary Charges, Self-injury or suicide, Treatment outside discipline, War, Wilful Act/Negligence

(Note- Please refer policy wordings for details of exclusions)

#### 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.



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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: \_\_\_\_\_

Time: \_\_\_\_\_

\_\_\_\_\_  
Proposer's Signature\*

\*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.

**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.

**DECLARATION & WARRANTY ON BEHALF OF MASTER POLICYHOLDER**

- I/We hereby declare, on behalf of Master Policyholder, 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.
- I hereby authorize IndusInd General Insurance Company Limited to collect the information provided by me. The Company may deal with this information for the purposes as detailed under the Company's Privacy Policy [<https://www.indusindinsurance.com>] and the Terms of Use [<https://www.indusindinsurance.com>] which I acknowledge to have been understood by me and shall be bound by the same. I shall have the right to withdraw such consent at any given time by intimating as such to the Company in writing.



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- I have read & understood the full texts, features, disclosures, terms, conditions & exclusions under the product(s)
- We consent to receive information from the Company through physical, electronic or telecommunication means from time to time.
- We hereby declare and warrant on our behalf & on behalf of all persons proposed to be insured that the above statements, answers and/or particulars given by us in this proposal form 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/We here by state that the above mentioned address shall be taken as address on record for the purpose of GST.
- I/We here by confirm that the contents of the proposal form and connected documents have been fully explained to me/us and I/We have fully understood the significance of proposed contract.

Place: \_\_\_\_\_

Date: \_\_\_\_\_

\_\_\_\_\_  
Signature of Proposer & Seal of Company

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

[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/ IndusInd General Insurance Company Limited, 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 Health. 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.

**VERNACULAR DECLARATION**

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)

Explained By Intermediary (Name):  Mr.  Ms.  Mrs. F I R S T M I D D L E L A S T

Date: DD/MM/YYYY

Place: \_\_\_\_\_

Place: \_\_\_\_\_

Date: \_\_\_\_\_

\_\_\_\_\_  
Signature of Intermediary

**PROHIBITION OF REBATES- SECTION 41 OF THE INSURANCE LAWS (AMENDMENT) ACT, 2015:**

1. No person shall allow or offer to allow, either directly or indirectly, as an inducement to any person to take out or renew or continue an insurance in respect of any kind of risk relating to lives or property in India, any rebate of the whole or part of the commission payable or any rebate of the premium shown on the policy, nor shall any person taking out or renewing or continuing a policy accept any rebate, except such rebate as may be allowed in accordance with the published prospectuses or tables of the insurer.
2. Any person making default in complying with the provisions of this section shall be liable for a penalty which may extend to ten lakh rupees.



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**ANNEXURE ATTACHED TO THE PROPOSAL FORM  
COVER DETAILS (FOR REFERENCE ONLY)**

The below descriptions are indicative. Please refer the Policy Wordings for complete description, terms and conditions relating to the Covers listed below.

**Daily Cash Amount: Benefit options ranging from minimum Rs 500 to maximum Rs 10000**

Benefit Title	Payout	Sub-limits/ Deductible	Options	Minimum Benefit	Maximum Benefit	Maximum Liability
<b>Base Covers</b>						
1. In Patient Treatment	Daily Cash Amount per day (24 hours) of continuous In-patient hospitalization. This shall also cover AYUSH Treatment, maximum upto 15 days taken on In-Patient basis.	AYUSH Treatment, maximum upto 15 days of In- Patient Treatment	Option of 30/60/90/180 days	500*30	10000*180	Daily Cash Amount* Selected max. no.of days
2. ICU Cover	Additional 100% of Daily Cash Amount per day (24 hours) of continuous ICU hospitalization, maximum up to 15 days for 30 days In- Patient Treatment, and 30 days for 60/90/180 days of In-Patient Treatment	-	Option of 15/30 days	15 days	30 days	Daily Cash Amount* 100% *(15 or 30 days as per plan)
3. Day Care Treatments	Lump sum amount equal to Daily Cash Amount for each Incidence of Day Care Treatment	Payable five times in a Policy Period	-	500*5	10000*5	Daily Cash Amount *5
<b>Optional Covers</b>						
4. Convalescence Cover	Selected Lump sum amount, where In-patient Hospitalization is for minimum 10 days.	Payable once in a Policy Year	Options: 3 times, 5 times, 10 times of Daily Cash Amount	500*3	10000*10	Daily Cash Amount * (3 or 5 or 10)
5. Personal Accident Cover	Lumpsum amount up to selected Personal Accident Sum Insured for: • Accidental Death, • Permanent Total Disability, • Permanent Partial Disability	Personal Accident Sum Insured For Dependent children-20% of Personal Accident Sum Insured of Policyholder	Personal Accident Sum Insured Options-ranges from 5lakhs to 100 lakhs(in multiples of 5 lakhs)	500000	10000000	Personal Accident Sum Insured
6. Accidental Medical Expenses*	Medical expenses on indemnity basis for: • In-Patient Treatment • Day Care Treatment • OPD	20% of the Personal Accident Sum Insured, maximum upto Rs. 5 lakhs. Deductible of Rs. 1000 applicable on each and every OPD claim.	-	20% *500000	500000	20% of Personal Accident Sum Insured, (maximum upto Rs. 5 lakhs)
7. Companion Cover	Additional 50% of Daily Cash Amount per day (24 hours) of continuous In-patient hospitalization	Same as opted under Benefit 1	-	500*50%*30	10000*50%*180	Daily Cash Amount *50% *Selected max. no. of days for Benefit-1



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8. Maternity Cover	Lumpsum payment of 5 times of Daily Cash or Rs 35000 whichever is lower	Maximum two claims payable in a lifetime 12 months Waiting Period	-	5*500	35000	5 times of Daily Cash Amount or Rs 35000 whichever is lower
9. Leave Compensation Benefit	Per Day compensation, equal to 135% of: the daily basic salary before tax or the Daily Cash amount whichever is lower.	Maximum of 90 days; Payable on completion of 4 continuous and consecutive days of In-Patient Hospitalization	-	500*135%*90	10000*135%*90	Daily Cash amount* 135%*90days
10. Time Deductible	Selected Deductible shall be applicable on each and every In-Patient Hospitalization claim for a discount on premium	Time Deductible shall not be applicable to Benefit-3 (Day Care Treatments), Benefit-4 (Convalescence Cover), Benefit-5 (Personal Accident Cover), Benefit-6 (Accidental Medical Expenses) and Benefit-8 (Maternity Cover), and Benefit-9 (Leave Compensation Benefit)	Time deductible Options: 24/48/72 hours.	-	-	-
11. Waiver of Waiting Period for Pre-Existing Disease	This Cover shall reduce the Waiting Period for Pre- Existing Diseases to zero months, 12 months or 24 months as the case may be.	-	Options are: zero months, 12 months or 24 months	-	-	-
12. Waiver of Waiting Period for Specified disease/ procedure	This Cover shall reduce the Waiting Period for Specified Diseases to zero months or 12 months as the case may be.	-	Options are: zero months or 12 months	-	-	-
13. Waiver of 30 days Waiting Period	This Cover waives off the Initial 30 Days Waiting Period Condition					
14. Waiver of Waiting Period for Maternity Cover	This Cover waives off the 12 months Maternity Cover Waiting Period Condition.					

\*Benefit-6 Accidental Medical Expenses shall only be available if Benefit -5 Personal Accident Cover has been opted under the Policy

Note-The Total Liability of the Company with respect to any one Insured Person during a given Policy Period shall be limited to the total of the cover wise (as opted) maximum liability listed in the above table.



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2024