IndusInd GENERAL INSURANCE
FORMERLY RELIANCE GENERAL INSURANCE

Tech + ♥ = Live Smart

Proposal Form No.: _____

Date: _____

INDUSIND – INBOUND TRAVEL (GROUP) - PROPOSAL FORM - PLAN A (CERTIFICATE HOLDER)

a. To be filled and signed by Proposer and all fields are mandatory to be filled.
b. This Proposal shall be the basis of construct for Policy issuance.
c. IndusInd General Insurance Company Limited (the "Company") is under no obligation to accept any proposal for insurance. The liability of the Company commences only when this proposal is accepted by the Company and the premium is received. If the Company accepts a proposal for insurance, it shall be subject to Policy Terms and Conditions.

INTERMEDIARY DETAILS			
Intermediary Name		Code	
IMD Branch Name		Code	
Employee Code			

PROPOSER DETAILS (All the details are mandatory)			
Name	☐ Mr. ☐ Ms. ☐ Mrs.		
Permanent Address:			
City		Pinode	
State			
Correspondence Address:			
City		Pinode	
State			
Contact Number	Primary No.:	Secondary No.:	
E-mail Id			
Date of Birth (Mandatory)	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, please specify:		
Monthly income	☐ Up to Rs. 20000 ☐ Rs. 20001 to Rs. 50000 ☐ Rs. 50001 to Rs. 100000 ☐ Rs. 100000 & above		
Source of Income	☐ Business ☐ Profession ☐ Salary ☐ Agricultural Income ☐ Savings ☐ Others		
Pan No.: (Mandatory) If not provided, Form 60 required			
Aadhar No.:			
CKYC No.:	(for Individual customer)		
GST Registration No.:	(if applicable)		

Business Type: (New Business/ Renewal)			
Customer ID		Bank Account No.	

POLICY DETAILS (Tick/Fill the required option) (All fields are mandatory)		
Cover Type*	☐ Individual ☐ Floater	
Family Covered	☐ Yes ☐ No	
Medical Cover Sum Insured:		
Personal Accident Cover Sum Insured:		
Plan Type	Plan A	
Trip Type	Single Trip	
Purpose of Trip	Leisure / Visiting friends and family / Work / Student Program ☐ I confirm that none of the persons proposed hereunder are travelling for the purpose of obtaining medical treatment.	
Trip Duration	From D D / M M / Y Y Y Y	To D D / M M / Y Y Y Y
**If floater cover opted, Floater Sum Insured shall be applicable only on Medical Cover (if opted)*		

Benefit No. (Reference Policy Wordings)	**Cover Name**	**Sum Insured Limits for Plan A**	**Deductibles**
3.1	**Medical Covers**		
3.1.1	Hospitalization Expenses	As per Group Policy Schedule	As per Group Policy Schedule
	Emergency Hospitalization Expenses • In-Patient Treatment • Day Care Treatment	As per Group Policy Schedule	
3.1.2	Daily Allowance	As per Group Policy Schedule	As per Group Policy Schedule
3.1.7	Post Hospitalization	As per Group Policy Schedule	As per Group Policy Schedule
3.1.8	Transportation(Road Ambulance)	As per Group Policy Schedule	As per Group Policy Schedule
3.1.9	Medical Emergency Evacuation and Air Ambulance	As per Group Policy Schedule	As per Group Policy Schedule
3.1.10	Repatriation of Mortal Remains	As per Group Policy Schedule	As per Group Policy Schedule
3.1	**Accidental Cover**		
3.2.1	**Personal Accident**		
3.2.1.1	Accidental Death	Mandatory	-
3.2.1.2	Permanent Total Disability		
3.2.1.3	Accidental Death – Common Carrier		
3.2.2	Accidental Hospitalization Medical Expenses	As per Group Policy Schedule (If Medical Cover is not opted)	As per Group Policy Schedule (If Medical Cover is not opted)

3.3	**OPD Cover**	As per Group Policy Schedule (If Medical Cover is not opted)	As per Group Policy Schedule (If Medical Cover is not opted)
3.4	**Itinerary Cover**		
3.4.1	Trip Cancellation		
	Option-1 Due to listed Perils	As per Group Policy Schedule (If Medical Cover is not opted)	As per Group Policy Schedule (If Medical Cover is not opted)
	Option-2 Cancellation for any reason	As per Group Policy Schedule (If Medical Cover is not opted)	As per Group Policy Schedule (If Medical Cover is not opted)
3.4.2	Trip Delay*	As per Group Policy Schedule (If Medical Cover is not opted)	As per Group Policy Schedule (If Medical Cover is not opted)
3.4.3	Trip Interruption*	As per Group Policy Schedule (If Medical Cover is not opted)	As per Group Policy Schedule (If Medical Cover is not opted)
3.4.4	Hijack Distress Allowance*	As per Group Policy Schedule (If Medical Cover is not opted)	As per Group Policy Schedule (If Medical Cover is not opted)
3.4.5	Missed Connections	As per Group Policy Schedule (If Medical Cover is not opted)	As per Group Policy Schedule (If Medical Cover is not opted)
3.4.6	Total Loss Of Checked In Baggage	As per Group Policy Schedule (If Medical Cover is not opted)	As per Group Policy Schedule (If Medical Cover is not opted)
3.4.7	Delay Of Checked In Baggage	As per Group Policy Schedule (If Medical Cover is not opted)	As per Group Policy Schedule (If Medical Cover is not opted)
3.4.8	Bounced Bookings of Airlines and Hotel	As per Group Policy Schedule (If Medical Cover is not opted)	As per Group Policy Schedule (If Medical Cover is not opted)
3.4.9	Up-gradation to Business Class	As per Group Policy Schedule (If Medical Cover is not opted)	As per Group Policy Schedule (If Medical Cover is not opted)
3.4.10	Lounge Access	As per Group Policy Schedule (If Medical Cover is not opted)	As per Group Policy Schedule (If Medical Cover is not opted)
3.5	**Value Added and Assistance Cover**		
3.5.1	Compassionate Visit	As per Group Policy Schedule (If Medical Cover is not opted)	As per Group Policy Schedule (If Medical Cover is not opted)
3.5.2	Return of Minor Child	As per Group Policy Schedule (If Medical Cover is not opted)	As per Group Policy Schedule (If Medical Cover is not opted)
3.5.3	Loss of Passport*	As per Group Policy Schedule (If Medical Cover is not opted)	As per Group Policy Schedule (If Medical Cover is not opted)
3.5.4	Loss of International Driving License*	As per Group Policy Schedule (If Medical Cover is not opted)	As per Group Policy Schedule (If Medical Cover is not opted)

3.5.6	Emergency Assistance Service (Cash Assistance, Translator, Loss of Passport Assistance, Legal Assistance, Emergency Travel and Accommodation Arrangements)	As per Group Policy Schedule (If Medical Cover is not opted)	As per Group Policy Schedule (If Medical Cover is not opted)
3.5.7	Personal Liability	As per Group Policy Schedule (If Medical Cover is not opted)	As per Group Policy Schedule (If Medical Cover is not opted)
3.6	**Adventure Sports**	As per Group Policy Schedule (If Medical Cover is not opted)	As per Group Policy Schedule (If Medical Cover is not opted)

DETAILS OF PERSON(S) PROPOSED TO BE INSURED

Section A: Personal Details

Details	Member 1	Member 2	Member 3	Member 4
Name of Insured Person				
Gender (M/F/Other)				
Date of Birth				
Relationship with Proposer				
Occupation				
Nationality				
Passport Number				
First State of visit				
Country Visiting				

DETAILS OF PERSON(S) PROPOSED TO BE INSURED

Section A: Personal Details

Details	Member 5	Member 6	Member 7	Member 8
Name of Insured Person				
Gender (M/F/Other)				
Date of Birth				
Relationship with Proposer				
Occupation				
Nationality				
Passport Number				
First State of visit				
Country Visiting				

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 Insured	Name of Nominee	Date of Birth	Relationship with Insured	Address of Nominee
		D D / M M / Y Y Y Y		
		D D / M M / Y Y Y Y		
		D D / M M / Y Y Y Y		
		D D / M M / Y Y Y Y		
		D D / M M / Y Y Y Y		
		D D / M M / Y Y Y Y		
		D D / M M / Y Y Y Y		
		D D / M M / Y Y Y Y		

Medical Questions	Member 1	Member 2	Member 3	Member 4
The following medical questions are compulsory for each member.				
Is any person proposed to be insured presently suffering (or suffered in the past 15 days) from any disease / illness / injury?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Is any person proposed is planning to undergo any surgery at present or in the near future? If Yes, pls provide details.	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Is any person proposed to be insured diagnosed with any of these medical conditions with or without any follow-up tests/ medications?				
Diabetes	☐ Yes ☐ No Suffering Since XXXXXXXX	☐ Yes ☐ No Suffering Since XXXXXXXX	☐ Yes ☐ No Suffering Since XXXXXXXX	☐ Yes ☐ No Suffering Since XXXXXXXX
Hypertension	☐ Yes ☐ No Suffering Since XXXXXXXX	☐ Yes ☐ No Suffering Since XXXXXXXX	☐ Yes ☐ No Suffering Since XXXXXXXX	☐ Yes ☐ No Suffering Since XXXXXXXX
High Cholesterol or high triglycerides	☐ Yes ☐ No Suffering Since XXXXXXXX	☐ Yes ☐ No Suffering Since XXXXXXXX	☐ Yes ☐ No Suffering Since XXXXXXXX	☐ Yes ☐ No Suffering Since XXXXXXXX
Hypothyroidism or Pituitary disorder	☐ Yes ☐ No Suffering Since XXXXXXXX	☐ Yes ☐ No Suffering Since XXXXXXXX	☐ Yes ☐ No Suffering Since XXXXXXXX	☐ Yes ☐ No Suffering Since XXXXXXXX
Liver Cirrhosis	☐ Yes ☐ No Suffering Since XXXXXXXX	☐ Yes ☐ No Suffering Since XXXXXXXX	☐ Yes ☐ No Suffering Since XXXXXXXX	☐ Yes ☐ No Suffering Since XXXXXXXX

HIV/AIDS	☐ Yes ☐ No Suffering Since XXXXXXXX	☐ Yes ☐ No Suffering Since XXXXXXXX	☐ Yes ☐ No Suffering Since XXXXXXXX	☐ Yes ☐ No Suffering Since XXXXXXXX
Unexplained Weight loss (> 5kg) in last 6 months	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Is any of the Insured Person Pregnant? If yes, please mention the date of delivery.	☐ Yes ☐ No Date of Delivery D D / M M / Y Y Y Y	☐ Yes ☐ No Date of Delivery D D / M M / Y Y Y Y	☐ Yes ☐ No Date of Delivery D D / M M / Y Y Y Y	☐ Yes ☐ No Date of Delivery D D / M M / Y Y Y Y
Others, please specify	☐ Yes ☐ No Disease name XXXXXXXX Suffering Since XXXXXXXX	☐ Yes ☐ No Disease name XXXXXXXX Suffering Since XXXXXXXX	☐ Yes ☐ No Disease name XXXXXXXX Suffering Since XXXXXXXX	☐ Yes ☐ No Disease name XXXXXXXX Suffering Since XXXXXXXX
Has any application for Travel Insurance, for any person proposed to be insured ever been declined?	☐ Yes ☐ No Details XXXXXXXX	☐ Yes ☐ No Details XXXXXXXX	☐ Yes ☐ No Details XXXXXXXX	☐ Yes ☐ No Details XXXXXXXX

Medical Questions	**Member 5**	**Member 6**	**Member 7**	**Member 8**
The following medical questions are compulsory for each member.				
Is any person proposed to be insured presently suffering (or suffered in the past 15 days) from any disease / illness / injury?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Is any person proposed is planning to undergo any surgery at present or in the near future? If Yes, pls provide details.	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Is any person proposed to be insured diagnosed with any of these medical conditions with or without any follow-up tests/ medications?				
Diabetes	☐ Yes ☐ No Suffering Since XXXXXXXX	☐ Yes ☐ No Suffering Since XXXXXXXX	☐ Yes ☐ No Suffering Since XXXXXXXX	☐ Yes ☐ No Suffering Since XXXXXXXX
Hypertension	☐ Yes ☐ No Suffering Since XXXXXXXX	☐ Yes ☐ No Suffering Since XXXXXXXX	☐ Yes ☐ No Suffering Since XXXXXXXX	☐ Yes ☐ No Suffering Since XXXXXXXX
High Cholesterol or high triglycerides	☐ Yes ☐ No Suffering Since XXXXXXXX	☐ Yes ☐ No Suffering Since XXXXXXXX	☐ Yes ☐ No Suffering Since XXXXXXXX	☐ Yes ☐ No Suffering Since XXXXXXXX
Hypothyroidism or Pituitary disorder	☐ Yes ☐ No Suffering Since XXXXXXXX	☐ Yes ☐ No Suffering Since XXXXXXXX	☐ Yes ☐ No Suffering Since XXXXXXXX	☐ Yes ☐ No Suffering Since XXXXXXXX

Liver Cirrhosis	☐ Yes ☐ No Suffering Since XXXXXXXX	☐ Yes ☐ No Suffering Since XXXXXXXX	☐ Yes ☐ No Suffering Since XXXXXXXX	☐ Yes ☐ No Suffering Since XXXXXXXX
HIV/AIDS	☐ Yes ☐ No Suffering Since XXXXXXXX	☐ Yes ☐ No Suffering Since XXXXXXXX	☐ Yes ☐ No Suffering Since XXXXXXXX	☐ Yes ☐ No Suffering Since XXXXXXXX
Unexplained Weight loss (> 5kg) in last 6 months	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Is any of the Insured Person Pregnant? If yes, please mention the date of delivery.	☐ Yes ☐ No Date of Delivery D D / M M / Y Y Y Y	☐ Yes ☐ No Date of Delivery D D / M M / Y Y Y Y	☐ Yes ☐ No Date of Delivery D D / M M / Y Y Y Y	☐ Yes ☐ No Date of Delivery D D / M M / Y Y Y Y
Others, please specify	☐ Yes ☐ No Disease name XXXXXXXX Suffering Since XXXXXXXX	☐ Yes ☐ No Disease name XXXXXXXX Suffering Since XXXXXXXX	☐ Yes ☐ No Disease name XXXXXXXX Suffering Since XXXXXXXX	☐ Yes ☐ No Disease name XXXXXXXX Suffering Since XXXXXXXX
Has any application for Travel Insurance, for any person proposed to be insured ever been declined?	☐ Yes ☐ No Details XXXXXXXX	☐ Yes ☐ No Details XXXXXXXX	☐ Yes ☐ No Details XXXXXXXX	☐ Yes ☐ No Details XXXXXXXX

PED Questions	**Member 1**	**Member 2**	**Member 3**	**Member 4**
If any of the medical questions are answered 'Yes', the proposed should be directed to the below PED questionnaire (information to be collected separately for each proposed person):				
Has the person proposed to be insured suffered from any of the following illnesses/sickness/medical conditions/medical procedures during the past 3 years?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Chest Pain or Heart Attack or any ailment/ diseases/ surgery of the Heart or arteries or other blood vessels?	☐ Yes ☐ No Date of first diagnosis D D / M M / Y Y Y Y	☐ Yes ☐ No Date of first diagnosis D D / M M / Y Y Y Y	☐ Yes ☐ No Date of first diagnosis D D / M M / Y Y Y Y	☐ Yes ☐ No Date of first diagnosis D D / M M / Y Y Y Y
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?	☐ Yes ☐ No Date of first diagnosis D D / M M / Y Y Y Y	☐ Yes ☐ No Date of first diagnosis D D / M M / Y Y Y Y	☐ Yes ☐ No Date of first diagnosis D D / M M / Y Y Y Y	☐ Yes ☐ No Date of first diagnosis D D / M M / Y Y Y Y
Any sexually transmitted diseases including Syphilis, Gonorrhoea, Genital Herpes, Chlamydia?	☐ Yes ☐ No Date of first diagnosis D D / M M / Y Y Y Y	☐ Yes ☐ No Date of first diagnosis D D / M M / Y Y Y Y	☐ Yes ☐ No Date of first diagnosis D D / M M / Y Y Y Y	☐ Yes ☐ No Date of first diagnosis D D / M M / Y Y Y Y

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?	☐ Yes ☐ No Date of first diagnosis D D / M M / Y Y Y Y	☐ Yes ☐ No Date of first diagnosis D D / M M / Y Y Y Y	☐ Yes ☐ No Date of first diagnosis D D / M M / Y Y Y Y	☐ Yes ☐ No Date of first diagnosis D D / M M / Y Y Y Y
Inflammatory Bowel Disease, Crohn's disease, Systemic Lupus Erythematosus or any other ailment of the digestive system?	☐ Yes ☐ No Date of first diagnosis D D / M M / Y Y Y Y	☐ Yes ☐ No Date of first diagnosis D D / M M / Y Y Y Y	☐ Yes ☐ No Date of first diagnosis D D / M M / Y Y Y Y	☐ Yes ☐ No Date of first diagnosis D D / M M / Y Y Y Y
Cancer, Leukemia, Papulosquamous disorder of skin, Tumor - malignant, or any growth or cyst anywhere in the body?	☐ Yes ☐ No Date of first diagnosis D D / M M / Y Y Y Y	☐ Yes ☐ No Date of first diagnosis D D / M M / Y Y Y Y	☐ Yes ☐ No Date of first diagnosis D D / M M / Y Y Y Y	☐ Yes ☐ No Date of first diagnosis D D / M M / Y Y Y Y
Rheumatoid arthritis, Avascular Necrosis, Ankylosing Spondylitis, Spinal Stenosis, Spondylosis, Multiple Sclerosis, Muscular Dystrophy or any other disorder of bone, muscles or joints?	☐ Yes ☐ No Date of first diagnosis D D / M M / Y Y Y Y	☐ Yes ☐ No Date of first diagnosis D D / M M / Y Y Y Y	☐ Yes ☐ No Date of first diagnosis D D / M M / Y Y Y Y	☐ Yes ☐ No Date of first diagnosis D D / M M / Y Y Y Y
Kidney transplant, Kidney/ Renal Failure, Stone in urinary tract, Prostate disorder or any other kidney disorder whether or not requiring dialysis?	☐ Yes ☐ No Date of first diagnosis D D / M M / Y Y Y Y	☐ Yes ☐ No Date of first diagnosis D D / M M / Y Y Y Y	☐ Yes ☐ No Date of first diagnosis D D / M M / Y Y Y Y	☐ Yes ☐ No Date of first diagnosis D D / M M / Y Y Y Y
Stroke, Epilepsy (fits), Paralysis, Demyelinating disease, Alzheimers Disease, Parkinsons Disease or any other disorder of the brain, spinal cord or nervous system?	☐ Yes ☐ No Date of first diagnosis D D / M M / Y Y Y Y	☐ Yes ☐ No Date of first diagnosis D D / M M / Y Y Y Y	☐ Yes ☐ No Date of first diagnosis D D / M M / Y Y Y Y	☐ Yes ☐ No Date of first diagnosis D D / M M / Y Y Y Y
Severe Anemia, Hemophilia, Idopathic Thrombocytopenia Purpura, Thalassemia (major), Peripheral Vascular Disease, Deep Vein Thrombosis, Lymphoma or any other blood/Lymphatic system disease or Sarcoidosis?	☐ Yes ☐ No Date of first diagnosis D D / M M / Y Y Y Y	☐ Yes ☐ No Date of first diagnosis D D / M M / Y Y Y Y	☐ Yes ☐ No Date of first diagnosis D D / M M / Y Y Y Y	☐ Yes ☐ No Date of first diagnosis D D / M M / Y Y Y Y
Diabetes with HbA1c >= 10 or fasting sugar above 250, Hypertension with three medication or blood pressure above 180/100?	☐ Yes ☐ No Date of first diagnosis D D / M M / Y Y Y Y	☐ Yes ☐ No Date of first diagnosis D D / M M / Y Y Y Y	☐ Yes ☐ No Date of first diagnosis D D / M M / Y Y Y Y	☐ Yes ☐ No Date of first diagnosis D D / M M / Y Y Y Y
Cerebral Palsy, any internal deformity or sickness from birth/ early childhood?	☐ Yes ☐ No Date of first diagnosis D D / M M / Y Y Y Y	☐ Yes ☐ No Date of first diagnosis D D / M M / Y Y Y Y	☐ Yes ☐ No Date of first diagnosis D D / M M / Y Y Y Y	☐ Yes ☐ No Date of first diagnosis D D / M M / Y Y Y Y

Loss of Hearing	☐ Yes ☐ No Date of first diagnosis D D / M M / Y Y Y Y	☐ Yes ☐ No Date of first diagnosis D D / M M / Y Y Y Y	☐ Yes ☐ No Date of first diagnosis D D / M M / Y Y Y Y	☐ Yes ☐ No Date of first diagnosis D D / M M / Y Y Y Y
Diseases of the Ear/Nose/ Throat/Teeth/ Eye (please mention Diopters in case of refractory error)?	☐ Yes ☐ No Date of first diagnosis D D / M M / Y Y Y Y	☐ Yes ☐ No Date of first diagnosis D D / M M / Y Y Y Y	☐ Yes ☐ No Date of first diagnosis D D / M M / Y Y Y Y	☐ Yes ☐ No Date of first diagnosis D D / M M / Y Y Y Y
Detoxication therapy for alcohol, narcotics, or any other habit-forming drugs?	☐ Yes ☐ No Date of first diagnosis D D / M M / Y Y Y Y	☐ Yes ☐ No Date of first diagnosis D D / M M / Y Y Y Y	☐ Yes ☐ No Date of first diagnosis D D / M M / Y Y Y Y	☐ Yes ☐ No Date of first diagnosis D D / M M / Y Y Y Y
Any other Illness/Injury: Please Specify	☐ Yes ☐ No Name of Disease/ condition Since: DD/MM/YYYY	☐ Yes ☐ No Name of Disease/ condition Since: DD/MM/YYYY	☐ Yes ☐ No Name of Disease/ condition Since: DD/MM/YYYY	☐ Yes ☐ No Name of Disease/ condition Since: DD/MM/YYYY

PED Questions	**Member 5**	**Member 6**	**Member 7**	**Member 8**
If any of the medical questions are answered 'Yes', the proposed should be directed to the below PED questionnaire (information to be collected separately for each proposed person):				
Has the person proposed to be insured suffered from any of the following illnesses/sickness/medical conditions/medical procedures during the past 3 years?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Chest Pain or Heart Attack or any ailment/ diseases/ surgery of the Heart or arteries or other blood vessels?	☐ Yes ☐ No Date of first diagnosis D D / M M / Y Y Y Y	☐ Yes ☐ No Date of first diagnosis D D / M M / Y Y Y Y	☐ Yes ☐ No Date of first diagnosis D D / M M / Y Y Y Y	☐ Yes ☐ No Date of first diagnosis D D / M M / Y Y Y Y
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?	☐ Yes ☐ No Date of first diagnosis D D / M M / Y Y Y Y	☐ Yes ☐ No Date of first diagnosis D D / M M / Y Y Y Y	☐ Yes ☐ No Date of first diagnosis D D / M M / Y Y Y Y	☐ Yes ☐ No Date of first diagnosis D D / M M / Y Y Y Y
Any sexually transmitted diseases including Syphilis, Gonorrhoea, Genital Herpes, Chlamydia?	☐ Yes ☐ No Date of first diagnosis D D / M M / Y Y Y Y	☐ Yes ☐ No Date of first diagnosis D D / M M / Y Y Y Y	☐ Yes ☐ No Date of first diagnosis D D / M M / Y Y Y Y	☐ Yes ☐ No Date of first diagnosis D D / M M / Y Y Y Y
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?	☐ Yes ☐ No Date of first diagnosis D D / M M / Y Y Y Y	☐ Yes ☐ No Date of first diagnosis D D / M M / Y Y Y Y	☐ Yes ☐ No Date of first diagnosis D D / M M / Y Y Y Y	☐ Yes ☐ No Date of first diagnosis D D / M M / Y Y Y Y

Inflammatory Bowel Disease, Crohn's disease, Systemic Lupus Erythematosus or any other ailment of the digestive system?	☐ Yes ☐ No Date of first diagnosis D D / M M / Y Y Y Y	☐ Yes ☐ No Date of first diagnosis D D / M M / Y Y Y Y	☐ Yes ☐ No Date of first diagnosis D D / M M / Y Y Y Y	☐ Yes ☐ No Date of first diagnosis D D / M M / Y Y Y Y
Cancer, Leukemia, Papulosquamous disorder of skin, Tumor - malignant, or any growth or cyst anywhere in the body?	☐ Yes ☐ No Date of first diagnosis D D / M M / Y Y Y Y	☐ Yes ☐ No Date of first diagnosis D D / M M / Y Y Y Y	☐ Yes ☐ No Date of first diagnosis D D / M M / Y Y Y Y	☐ Yes ☐ No Date of first diagnosis D D / M M / Y Y Y Y
Rheumatoid arthritis, Avascular Necrosis, Ankylosing Spondylitis, Spinal Stenosis, Spondylosis, Multiple Sclerosis, Muscular Dystrophy or any other disorder of bone, muscles or joints?	☐ Yes ☐ No Date of first diagnosis D D / M M / Y Y Y Y	☐ Yes ☐ No Date of first diagnosis D D / M M / Y Y Y Y	☐ Yes ☐ No Date of first diagnosis D D / M M / Y Y Y Y	☐ Yes ☐ No Date of first diagnosis D D / M M / Y Y Y Y
Kidney transplant, Kidney/ Renal Failure, Stone in urinary tract, Prostate disorder or any other kidney disorder whether or not requiring dialysis?	☐ Yes ☐ No Date of first diagnosis D D / M M / Y Y Y Y	☐ Yes ☐ No Date of first diagnosis D D / M M / Y Y Y Y	☐ Yes ☐ No Date of first diagnosis D D / M M / Y Y Y Y	☐ Yes ☐ No Date of first diagnosis D D / M M / Y Y Y Y
Stroke, Epilepsy (fits), Paralysis, Demyelinating disease, Alzheimers Disease, Parkinsons Disease or any other disorder of the brain, spinal cord or nervous system?	☐ Yes ☐ No Date of first diagnosis D D / M M / Y Y Y Y	☐ Yes ☐ No Date of first diagnosis D D / M M / Y Y Y Y	☐ Yes ☐ No Date of first diagnosis D D / M M / Y Y Y Y	☐ Yes ☐ No Date of first diagnosis D D / M M / Y Y Y Y
Severe Anemia, Hemophilia, Idopathic Thrombocytopenia Purpura, Thalassemia (major), Peripheral Vascular Disease, Deep Vein Thrombosis, Lymphoma or any other blood/Lymphatic system disease or Sarcoidosis?	☐ Yes ☐ No Date of first diagnosis D D / M M / Y Y Y Y	☐ Yes ☐ No Date of first diagnosis D D / M M / Y Y Y Y	☐ Yes ☐ No Date of first diagnosis D D / M M / Y Y Y Y	☐ Yes ☐ No Date of first diagnosis D D / M M / Y Y Y Y
Diabetes with HbA1c >= 10 or fasting sugar above 250, Hypertension with three medication or blood pressure above 180/100?	☐ Yes ☐ No Date of first diagnosis D D / M M / Y Y Y Y	☐ Yes ☐ No Date of first diagnosis D D / M M / Y Y Y Y	☐ Yes ☐ No Date of first diagnosis D D / M M / Y Y Y Y	☐ Yes ☐ No Date of first diagnosis D D / M M / Y Y Y Y
Cerebral Palsy, any internal deformity or sickness from birth/ early childhood?	☐ Yes ☐ No Date of first diagnosis D D / M M / Y Y Y Y	☐ Yes ☐ No Date of first diagnosis D D / M M / Y Y Y Y	☐ Yes ☐ No Date of first diagnosis D D / M M / Y Y Y Y	☐ Yes ☐ No Date of first diagnosis D D / M M / Y Y Y Y
Loss of Hearing	☐ Yes ☐ No Date of first diagnosis D D / M M / Y Y Y Y	☐ Yes ☐ No Date of first diagnosis D D / M M / Y Y Y Y	☐ Yes ☐ No Date of first diagnosis D D / M M / Y Y Y Y	☐ Yes ☐ No Date of first diagnosis D D / M M / Y Y Y Y

Diseases of the Ear/Nose/ Throat/Teeth/ Eye (please mention Diopters in case of refractory error)?	☐ Yes ☐ No Date of first diagnosis D D / M M / Y Y Y Y	☐ Yes ☐ No Date of first diagnosis D D / M M / Y Y Y Y	☐ Yes ☐ No Date of first diagnosis D D / M M / Y Y Y Y	☐ Yes ☐ No Date of first diagnosis D D / M M / Y Y Y Y
Detoxication therapy for alcohol, narcotics, or any other habit-forming drugs?	☐ Yes ☐ No Date of first diagnosis D D / M M / Y Y Y Y	☐ Yes ☐ No Date of first diagnosis D D / M M / Y Y Y Y	☐ Yes ☐ No Date of first diagnosis D D / M M / Y Y Y Y	☐ Yes ☐ No Date of first diagnosis D D / M M / Y Y Y Y
Any other Illness/Injury: Please Specify	☐ Yes ☐ No Name of Disease/ condition Since: DD/MM/YYYY	☐ Yes ☐ No Name of Disease/ condition Since: DD/MM/YYYY	☐ Yes ☐ No Name of Disease/ condition Since: DD/MM/YYYY	☐ Yes ☐ No Name of Disease/ condition Since: DD/MM/YYYY

PROPOSER BANK DETAILS			
Name of Bank Account Holder:	☐ Mr. ☐ Ms. ☐ Mrs.		
Bank Name:			
Bank Account Number:			
IFSC Code (11-character code appearing on your cheque leaf)		Account Type:	☐ Saving ☐ Current
MICR Code (9-digit MICR code number of the bank and branch appearing on the cheque issued by bank):		Branch:	

☐ 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.

PREMIUM PAYMENT DETAILS			
Payment by:	☐ Cheque ☐ DD ☐ Credit Card ☐ Debit Card ☐ NEFT ☐ Net Banking		
Cheque or DD amount in figures:	Rs.	Cheque/DD Date:	D D / M M / Y Y Y Y
Cheque or DD amount in words:	Rs.		
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

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

i. 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.

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.

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.

vi. I hereby declare, on my behalf and on behalf of all persons proposed to be insured that/we –

(a) will not be travelling against advice of Medical Practitioner

(b) are not on Waiting list for any medical treatment

(c) are not travelling for the purpose of obtaining medical treatment

(d) Have not received a terminal prognosis for a medical condition before Journey.

vii. I have read and understood the brochure, prospectus, sales literature & Policy wordings and confirm to abide by the same.

viii. Receipt of the Proposal form by the Company shall not be construed as acceptance of proposal. I hereby agree that the insurance coverage shall commence only on realization of full premium and on receipt of complete medical reports (wherever applicable) and subject to individual underwriting by the Company. The Company at its sole discretion reserves the right to accept or reject or load any proposal without assigning any reason thereof.

Other Declarations & Warranty on Behalf of all Persons Proposed to be Insured

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.

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.

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)** are individuals who are or have been entrusted with prominent public functions in a foreign country, e.g., Heads of States/Governments, senior politicians, senior government/judicial/military officers, senior executives of state-owned corporations, important political party officials, etc (As per sub clause (xii) of 3(b) of Chapter I of Master Direction – Know Your Customer (KYC) Direction, 2016 issued by Reserve Bank of India (RBI).

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

VERNACULAR DECLARATION (For Intermediary)

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

Place: _____

Date: _____

_____

Signature/Thumb impression of Intermediary

VERNACULAR DECLARATION (For all Persons Proposed to be Insured)

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

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

- 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.
- 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.

ACKNOWLEDGEMENT FOR PROPOSAL

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

Date:		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

Note - The Policy copy and all related documents shall be sent to the email ID provided above. If you wish to receive the Policy copy and related documents in physical form to the aforesaid communication address, please drop us an email at **services@indusindinsurance.com.**