IndusInd
GENERAL INSURANCE
FORMERLY RELIANCE GENERAL INSURANCE

Proposal Form No: ____________________

INDUSIND SPECIALLY ABLED HEALTH INSURANCE - PROPOSAL FORM

GUIDELINES FOR COMPLETION OF THE FORM

- This policy is specially designed for Persons with Disability and Persons with HIV/AIDS.

a. Persons with Disability shall be covered if 40% or more disability is certified by the Medical Board appointed by the government for certifying Disability as per the Disability Act 2016.

b. Persons who are HIV/ AIDS positive Individuals.

- Please answer all questions correctly and completely.
- Information for fields marked with asterisk (*) are mandatory.
- Only Indian Nationals can be covered under this policy.
- Only one policy can be purchased for this product across all insurers.
- Note: The Coverage proposed for insurance is not covered until the proposal is accepted and premium is paid and the same is realized by Name of the Insurance Company.

INTERMEDIARY DETAILS			
Intermediary Name			
Intermediary Code			
Intermediary Contact Details			
PROPOSER DETAILS* (To be filled in BLOCK LETTERS)			
Name	o Mr. o Ms. o Mrs.	FIRST MIDDLE LAST	
Communication Address			
Flat/Building		Road/Street / Sector	
Area		City	
Pin Code		State	
Country			
Phone		Mobile	
Email		Fax	
Profession:	o Salaried o Self-Employed o Other o Details: ____________		
Occupation and Nature of Business/ Work:			
PAN No./ form 60/61:		UID Aadhaar No. Please hide 1st 8 no. (Last four digits are mandatory.)	
Date of Birth	D D / M M / Y Y Y Y		
Gender	o Male o Female o Other		
COVERAGE DETAILS:			
Policy Type	Individual Basis		
Policy period	1 year		
Period of Insurance	From D D / M M / Y Y Y Y to D D / M M / Y Y Y Y		
Sum Insured	o 400000 o 500000		
Coverage opted:	o Pre-existing HIV/AIDS o Pre-existing Disability o Pre-existing HIV/AIDS and Disability		

OPTIONAL COVER:

Waiver of Co-pay:	o Yes o No

COVERAGE DETAILS:

Sr No	Name of the Insured	Nationality	Date of Birth	Age	Gender	Height	Weight	Occupation	Marital Status	Relation with Proposer
1.			DD/MM/YYYY		M/F/O					

NOMINEE DETAILS:

Name	Date of Birth	Age	Relationship with Insured
	DD/MM/YYYY		

Where Nominee is a minor, give the details of Appointee

Name of the Appointee	Date of Birth	Age	Relationship with Insured
	DD/MM/YYYY		

PREVIOUS/EXISTING HEALTH DETAILS OF INSURED:

Do you suffer from HIV/AIDS? o Yes o No

If Yes, please enclose a recent certificate of your current CD4 count (within past 30 days)

Current CD 4 count

Has your CD4 Count gone below 500 in the past 4 years? o Yes o No

If yes when and How many times

Do you suffer from any other illness/ disease related to/ arising of/ associated to HIV/AIDS? o Yes o No

If Yes, please give details:

Do you suffer from any disability as per the listed conditions mentioned below: o Yes o No

If Yes, please enclose Disability certificate mentioning percentage of disability wherever applicable.

1. Blindness o	2. Muscular Dystrophy o
3. Low vision o	4. Chronic Neurological conditions o
5. Leprosy Cured persons o	6. Specific Learning Disabilities o
7. Hearing Impairment (deaf and hard of hearing) o	8. Multiple Sclerosis o
9. Locomotor Disability o	10. Speech and Language disability o
11. Dwarfism o	12. Thalassemia o
13. Intellectual Disability o	14. Haemophilia o
15. Mental Illness o	16. Sickle Cell disease o
17. Autism spectrum disorder o	18. Multiple Disabilities including deaf/ blindness o
19. Cerebral Palsy o	20. Acid Attack victim o
21. Parkinson's disease o	

Do you suffer from any pre-existing illness other than Disability or HIV AIDS mentioned above? o Yes o No

If Yes, please specify details and the number of years you are suffering:

Do you have any other physical disability arising out of any illness / disease condition?

Any other previous medical details

PREVIOUS/EXISTING HEALTH INSURANCE DETAILS:

Policy No. / Application No.	Insurer Name	Period of Insurance (from – to)	Sum Insured	Claims lodged during the preceding years

Do you have the same policy from any one or other insurer? o Yes o No

If yes, Please share details below:

Policy No. / Application No.	Insurer Name	Period of Insurance (from – to)	Sum Insured	Claims lodged during the preceding years

ELECTRONIC INSURANCE ACCOUNT DETAILS SECTION:

I want ________________________________related information in

Physical Format	o Yes o No
e-Format (electronic) as & when applicable	o Yes o No
Choose your Insurance Repository (For those selecting e-Format)	(a)NSDL Data Management Ltd. (b)CDSL Insurance Repository Ltd (c)Karvy Insurance Repository Ltd. (d)CAMS Repository Services Ltd

I have e Insurance Account & the No. is

My CKYC No. (Central Know Your Customer registry number) is (If available)

PREMIUM PAYMENT DETAILS

Name of Premium Payer:			
Premium Payment Frequency:	Lumpsum		
Premium Amount (in INR):			
Instrument Type:		Cash/ Cheque/ Debit Card/ Credit Card/ Others	Please Specify: ____________
Date:	D D / M M / Y Y Y Y	Cheque No.:	
Bank Name:		Bank Account Number:	
IFSC Code:		Branch Name:	

BANK ACCOUNT DETAILS FOR PROCESS OF REFUND

Cheque will be issued in the name of the Proposer only.

In case of cancellation of policy, if premium was paid through credit card the refund amount would be credited to Credit Card account directly or refund will be paid through cheque. Please provide the following bank details and a copy of Cancelled Cheque if you opt for direct credit of refund/ claim into your bank account:(Cancelled Cheque should be of the same bank account in which the refund needs to be credited directly.

IndusInd Insurance App

Download Now

Name of Account holder	o Mr. o Ms. o Mrs. FIRST MIDDLE LAST		
Cheque No		Bank Name	
Branch Name		Cheque Date	
Cheque Amount for			
Name as in Bank Account		Bank Account No	
IFSC Code		MICR Code	

Note: The Proposer agrees and undertakes to intimate in writing to IndusInd General Insurance Co. Ltd. about any change in bank account details.

If ECS is selected, please submit the standing instruction form available at our branches.

Place: ________________________

Date: ________________________

____
Signature of Proposer

PEP DECLARATION:

Are you a Politically Exposed Person (PEP)?	o Yes o No
If yes, please mention the position held	
Is any of your close relation or family member a PEP?	o Yes o 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 stateowned 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: DD/MM/YYYY

____
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

IndusInd Insurance App

Download Now

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.

AGENT'S DECLARATION

I,______________________________________ (Full Name) in my capacity as an Insurance Advisor/ Specified Person of the Corporate Agent/Authorised employee of the Broker/Relationship Officer, do hereby declare that I have explained all the contents of this Proposal Form, including the nature of the questions contained in this Proposal Form to the Proposer including statement(s), information and response(s) submitted by him/her in this Proposal Form to questions contained herein or any details sought herein will form the basis of the Contract of Insurance between the Company and the Proposer, if this Proposal is accepted by the Company 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, the Company shall have the right to vary the benefits which may be payable and further more if there has been a non-disclosure of any material fact, the policy issued to his/her favour pursuant to this Proposal may be treated by the Company as null and void and all premiums paid under the Policy may be forfeited to the company.

Place: ----------------------------

Date: ----------------------------

Licence No.: ----------------------------

Signature of Agent

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

i. I/We hereby declare on my behalf and on behalf of all persons proposed to be insured that the above statements 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.

ii. I understand that the information provided by me will form the basis of insurance policy, is subject to the Board approved under writing policy of the Insurance company and that the policy will come into force only after full receipt to the premium chargeablec

iii. 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.

iv. I/We declare and further consent to the company. Seeking medical information from any hospital who at any time has attended on the life to be insured/proposer or from any past or present employer concerning anything which affects the physical and mental health of the life to be assured/proposer and seeking information from any insurance company to which an application or insurance on the life to be assured/proposer has been made for the purpose of underwriting the proposal and /or claim settlement.

v. 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.

vi. I/We aware of premium loading, (if any declared above) for habit's & diseases as declared / mention by me/ us above.

vii. I/ We hereby agree to keep record of KYC details of all the individual members covered under the group insurance, and ensure to provide the details of beneficiaries to the Company as and when required.

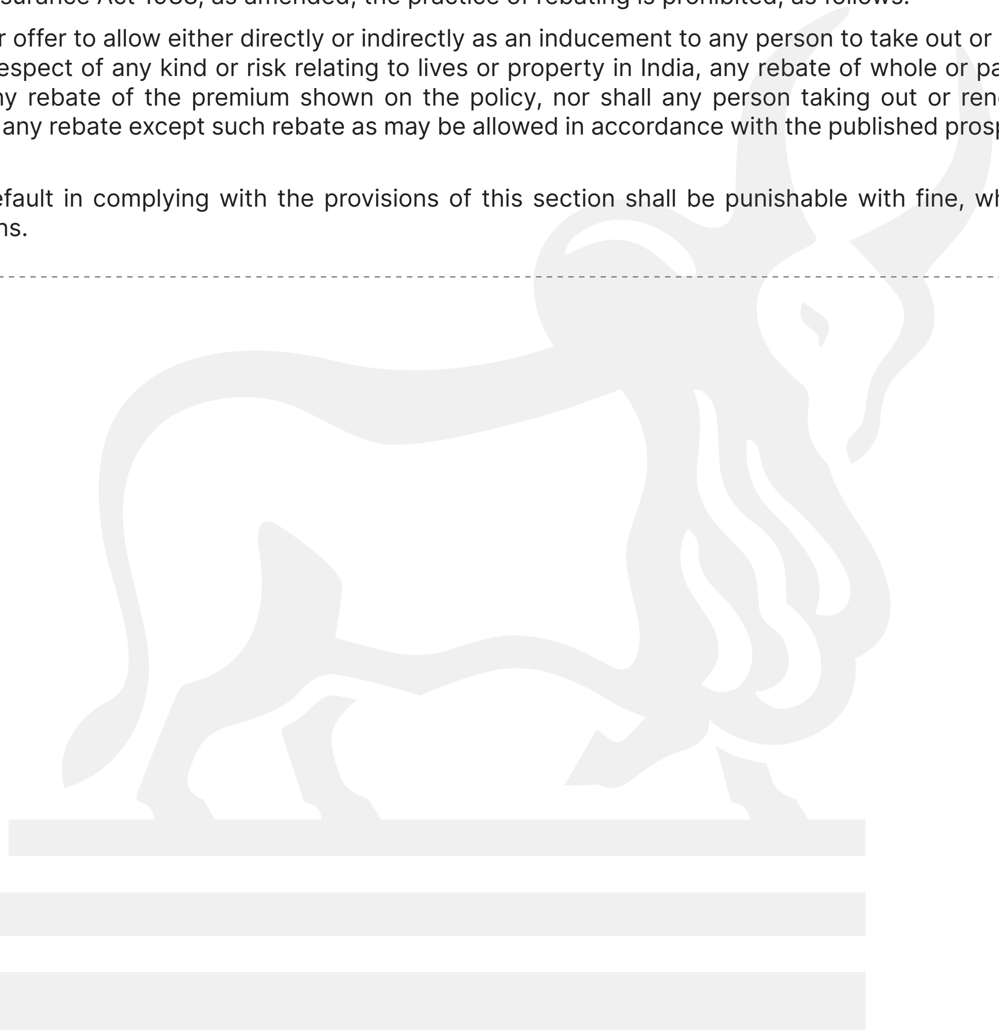
VERNACULAR DECLARATION

** Applicable where the Proposer is illiterate or is suffering from a disability due to which writing is restricted or where the Proposer has signed in vernacular language. (Note: The below must be witnessed by someone other than the Advisor/Employee of the Company).

I/We certify that the product applied for by me/us and the contents of the Proposal Form have been clearly explained to me/us and I/ we have fully understood them. I/We further certify that the replies in the Proposal Form have been recorded as per the information provided by me/us. I, (Full name of the witness) ______________________________ (Relation with the Proposer) ______________ adult and inhabitant of (city) _______ and residing at ________________ do hereby certify that I have read out and explained the contents of the Proposal Form and all other documents incidental to availing the insurance policy from IndusInd General Insurance Co. Ltd., to the Proposer and he/she/they have understood the same. I/we declare that whatever I/we have stated herein above is true and correct to the best of knowledge and belief.

Place: ....

Date: ....



.... Signature of the Witness

.... Signature/Thumb impression of the Proposer

SECTION 41 OF INSURANCE ACT, 1938

As per Section 41 of the Insurance Act 1938, as amended, the practice of rebating is prohibited, as follows:

(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 or risk relating to lives or property in India, any rebate of 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 punishable with fine, which may extend to Rupees Ten Lakhs.