

**INDUSIND TRAVEL CARE POLICY (INDIVIDUAL AND FAMILY PLAN) - PROPOSAL FORM**

- To be filled and signed by proposer
- This proposal shall be the basis of contract for Policy issuance.
- IndusInd General Insurance Company Ltd. (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 the Policy Terms and Conditions.

**Intermediary Details** (To be filled in BLOCK LETTERS)

Intermediary Name	Code
Branch Name	Code
Sales Manager Name	Code

**PROPOSER'S DETAILS** (To be filled in BLOCK LETTERS)

1. This proposal is for A new Policy

2a. Proposer's Full Name  Mr.  Mrs.  Ms. F I R S T M I D D L E L A S T

2. Address Communication Address Residential Address

Flat/Building/Door/Block No.

Road/Street/Sector

Nearest Landmark

Area

City

Pin Code

State

Country

Phone

Mobile

Passport No

Email Id

3. PAN No.

4. UID Aadhaar No.

5. CIN (In case of Corporate)

6. DOB

DD/MM/YYYY

7. CKYC No

(for Individual Customer)

Nature of employment (Income sources):

Salaried  Self-employed

**PROPOSER'S BANK DETAILS**

Name of the Bank Account Holder M/s  Mr.  Mrs.  Ms. F I R S T M I D D L E L A S T

Bank Account No.:

Account:

Saving  Current



Name of the Bank:	
Branch	
MICR Code (9 digit MICR code number of the bank and branch appearing on the cheque issued by the bank)	
IFSC Code (11 character code appearing on your cheque leaf)	
<input type="checkbox"/> I understand that any refund due on the premium payment I any payment I 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.	

### DETAILS OF PERSON(S) PROPOSED TO BE INSURED

#### Section A : Personal Details

Details		Member 1	Member 2*	Member 3*	Member 4*
Details	First name				
	Last name				
D.O.B		DD/MM/YYYY	DD/MM/YYYY	DD/MM/YYYY	DD/MM/YYYY
Gender					
Passport No.					
Nationality					
Relationship with Proposer					

### NOMINATION DETAILS

The nominee as declared hereunder shall become eligible for claim 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	D.O.B	Relationship with Proposer	Address of Nominee
		DD/MM/YYYY		
		DD/MM/YYYY		
		DD/MM/YYYY		
		DD/MM/YYYY		

### DISEASE / INJURY / MEDICATIONS DETAILS

Has any person to be insured been diagnosed/hospitalized/under any treatment for any illness / disease or injury during any time in past? If yes please select the disease / injury as mentioned below. If others, please specify

A. Diabetes (Not insulin based)	<input type="checkbox"/> Yes MM/YYYY	<input type="checkbox"/> Yes MM/YYYY	<input type="checkbox"/> Yes MM/YYYY	<input type="checkbox"/> Yes MM/YYYY
B. Hypertension	<input type="checkbox"/> Yes MM/YYYY	<input type="checkbox"/> Yes MM/YYYY	<input type="checkbox"/> Yes MM/YYYY	<input type="checkbox"/> Yes MM/YYYY
C. HIV/AIDS/STD	<input type="checkbox"/> Yes MM/YYYY	<input type="checkbox"/> Yes MM/YYYY	<input type="checkbox"/> Yes MM/YYYY	<input type="checkbox"/> Yes MM/YYYY
D. Liver disease(s)	<input type="checkbox"/> Yes MM/YYYY	<input type="checkbox"/> Yes MM/YYYY	<input type="checkbox"/> Yes MM/YYYY	<input type="checkbox"/> Yes MM/YYYY
E. Leukaemia / malignant tumour	<input type="checkbox"/> Yes MM/YYYY	<input type="checkbox"/> Yes MM/YYYY	<input type="checkbox"/> Yes MM/YYYY	<input type="checkbox"/> Yes MM/YYYY
F. Cardiac ailments	<input type="checkbox"/> Yes MM/YYYY	<input type="checkbox"/> Yes MM/YYYY	<input type="checkbox"/> Yes MM/YYYY	<input type="checkbox"/> Yes MM/YYYY
G. Arthritis / Joint pain	<input type="checkbox"/> Yes MM/YYYY	<input type="checkbox"/> Yes MM/YYYY	<input type="checkbox"/> Yes MM/YYYY	<input type="checkbox"/> Yes MM/YYYY
H. Kidney Disease(s)	<input type="checkbox"/> Yes MM/YYYY	<input type="checkbox"/> Yes MM/YYYY	<input type="checkbox"/> Yes MM/YYYY	<input type="checkbox"/> Yes MM/YYYY
I. Paralysis/Stroke	<input type="checkbox"/> Yes MM/YYYY	<input type="checkbox"/> Yes MM/YYYY	<input type="checkbox"/> Yes MM/YYYY	<input type="checkbox"/> Yes MM/YYYY
J. Congenital Disease(s)	<input type="checkbox"/> Yes MM/YYYY	<input type="checkbox"/> Yes MM/YYYY	<input type="checkbox"/> Yes MM/YYYY	<input type="checkbox"/> Yes MM/YYYY
K. Injury	<input type="checkbox"/> Yes MM/YYYY	<input type="checkbox"/> Yes MM/YYYY	<input type="checkbox"/> Yes MM/YYYY	<input type="checkbox"/> Yes MM/YYYY
L. Thalassaemia	<input type="checkbox"/> Yes MM/YYYY	<input type="checkbox"/> Yes MM/YYYY	<input type="checkbox"/> Yes MM/YYYY	<input type="checkbox"/> Yes MM/YYYY

M. Obstetrics/Pregnancy	<input type="checkbox"/> Yes MM/YYYY	<input type="checkbox"/> Yes MM/YYYY	<input type="checkbox"/> Yes MM/YYYY	<input type="checkbox"/> Yes MM/YYYY
N. Neurological disorders	<input type="checkbox"/> Yes MM/YYYY	<input type="checkbox"/> Yes MM/YYYY	<input type="checkbox"/> Yes MM/YYYY	<input type="checkbox"/> Yes MM/YYYY
O. Any known Allergies?				
P. Others (Please specify) Name of Illness / Injury				
Since	MM/YYYY	MM/YYYY	MM/YYYY	MM/YYYY
Current Medications				
P. Does any person proposed to be insured smoke or consume tobacco or alcohol? If yes, Please indicate	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

**EXISTING HEALTH INSURANCE DETAILS (If any)**

Name of Insurance Company

Policy Number

Customer ID

**TRIP DETAILS**

Travel Start Date

DD/MM/YYYY

Travel End Date

DD/MM/YYYY

Are you visiting USA/ Canada?

Yes  No

Countries that you are visiting

\_\_\_\_\_ Multiple countries to be separated with comma

Reason for visit

Business/work  Leisure  Study  Employment  Others (Please specify)

Will you be participating in any sporting activities during the trip?

Yes  No

If yes Details

**PLAN DETAILS (PLEASE SELECT PLAN OF YOUR CHOICE)**

PRIMARY CARE

(USD 50000)

P1

P2

ECONOMY CARE

(USD100000)

E1

E2

VALUE CARE

(USD 250000)

V1

V2

CLASSIC CARE

(USD 500000)

C1

C2

PREMIER CARE

(USD 750000)

P1

P2

ULTIMATE CARE

(USD 1000000)

U1

U2

(Please refer policy wordings, prospectus and annexure for details of plan)

**FAMILY PHYSICIANS DETAILS**

Name of Physician:

Mr.  Mrs.  Ms. F I R S T M I D D L E L A S T

Qualification:

Address:

Contact Number:

Email Id:

**PREMIUM PAYMENT DETAILS**

Payment by	<input type="checkbox"/> Cheque <input type="checkbox"/> DD <input type="checkbox"/> Credit Card# <input type="checkbox"/> Debit Card # (Tick whichever is applicable)		
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Cheque or DD Amount	₹	Amount in words	₹
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Bank Name	
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Cheque/DD No./Card No.	Cheque/DD Date	D D / M M / Y Y Y Y
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Name of the Premium Payer	
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\*In case of payment made through Cheque / DD then please issue an A/c payee instrument in favour of "IndusInd Insurance Company Limited" #In case of payment made through Credit/ Debit Card the Card needs to be in the name of the Proposer

**PEP DECLARATION:**

Are you a Politically Exposed Person (PEP)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
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If yes, please mention the position held	
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Is any of your close relation or family member a PEP?	<input type="checkbox"/> Yes <input type="checkbox"/> No
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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 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: \_\_\_\_\_

Proposer

Signature of

**GENERAL DECLARATION:**

I understand that as per the new AML/CFT Guidelines issued IndusInd 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 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.

I/We hereby declare, on my behalf and on behalf of all individuals proposed to be insured, that the aggregate premium for this insurance proposal, including all existing policies issued by IndusInd Insurance Company Limited, has not exceeded Rs. 10,000/- per annum.

**DECLARATION & WARRANTY ON BEHALF OF ALL PERSONS PROPOSER TO BE INSURED**

- I/We hereby declare, on my behalf and on behalf of all persons proposed to be insured, that the above statements, answers and/or particulars given by me are true and complete in all respects to the best of my knowledge and that I am authorised to propose on behalf of these other persons.
- 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 receipt 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 from a 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 or mental health of the life 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 assistance and 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 claim assistance and settlement and with any Governmental and/or Regulatory authority."
- I/We have read and understood the Privacy Policy of your Company and I hereby unconditionally agree and bind myself to all terms and conditions of your Privacy Policy, as amended, from time to time.
- I/We here by state that the above mentioned address shall be taken as address on record for the purpose of GST.
- I/We hereby 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 the proposed contract.

Vernacular Declaration stating that the contents of this proposal form have been read over & fully explained to me in \_\_\_\_\_ language. I further confirm & declare that contents read over & explained to me have been understood by me.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Signature/Thumb Impression of the Proposer

Identified by Name & Signature

Date: D D / M M / Y Y Y Y

Place:

**ACKNOWLEDGEMENT: FOR PROPOSAL**

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

**NOT VALID AGAINST CASH**

Proposal Form No. \_\_\_\_\_

Date \_\_\_\_\_ D D / M M / Y Y Y Y

We acknowledge the receipt of payment ₹ \_\_\_\_\_ vide cheque/DD. \_\_\_\_\_ 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 Insurance Company Limited is not liable for any claim between the time that 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 form, premium payment, medical reports (wherever applicable) and underwriting decision of the Company.

Name of the Employee:  Mr.  Mrs.  Ms. F I R S T M I D D L E L A S T

Signature of the Employee:

Company Seal & Stamp

**PROHIBITION OF REBATES - SECTION 41 OF THE INSURANCE ACT, 1938 AS AMENDED BY 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.



**ANNEXURE**

t	Plan:	Primary Care		Economy Care		Value Care		Classic Care		Premier Care		Ultimate Care		Deductible	
		1	2	1	2	1	2	1	2	1	2	1	2		
	Coverage														
		Sum Insured and deductible is in US \$ unless specified otherwise													
1	Medical Expenses Including Transportation, Evacuation And Repatriation of Mortal Remains	50000		100000		250000		500000		750000		1000000		50	
2	Dental Treatment	500 (max. 100 per tooth)	500 (max. 100 per tooth)	500 (max. 100 per tooth)	500 (max. 100 per tooth)	500 (max. 100 per tooth)	500 (max. 100 per tooth)	500 (max. 100 per tooth)	500 (max. 100 per tooth)	500 (max. 100 per tooth)	500 (max. 100 per tooth)	500 (max. 100 per tooth)	500 (max. 100 per tooth)	50	
3	Daily Allowance In Case Of Hospitalization	-	25 per day (5 days max)	25 per day (5 days max)	25 per day (6 days max)	25 per day (6 days max)	25 per day (7 days max)	25 per day (7 days max)	25 per day (8 days max)	25 per day (8 days max)	25 per day (8 days max)	25 per day (10 days max)	25 per day (10 days max)	2 days	
4	Personal Accident	15000	20000	20000	25000	30000	30000	30000	30000	30000	30000	35000	35000	Nil	
5	Accidental Death – Common Carrier	2500	2500	2500	5000	5000	5000	5000	5000	7500	7500	10000	10000	Nil	
6	Reinstatement of SI in case of Accidental Hospitalisation	-	100% of SI	-	100% of SI	-	100% of SI	-	100% of SI	-	100% of SI	100% of SI	100% of SI	Nil	
7	Trip Cancellation	-	600	600	600	600	600	600	600	750	750	1250	1250	Nil	
8	Trip Delay	-	25 per day (6 days max)	25 per day (6 days max)	50 per day (6 days max)	60 per day (6 days max)	60 per day (6 days max)	60 per day (6 days max)	75 per day (6 days max)	75 per day (6 days max)	75 per day (6 days max)	75 per day (6 days max)	75 per day (6 days max)	3 hours	
9	Trip Interruption	-	600	600	600	600	600	600	750	750	1250	1250	Nil		
10	Missed Connections	-	200	200	300	500	500	500	1000	1000	1000	1000	1000	3 hours	
11	Total Loss Of Checked In Baggage	500	1000	1000	1200	1500	1500	1500	1500	1500	1500	1500	1500	Nil	
12	Delay Of Checked In Baggage	100	100	100	100	100	100	100	100	100	100	100	100	12 Hours	
13	Bounced Bookings of Airlines and Hotel	-	-	500	500	500	500	750	750	1000	1000	2000	2000	10% of the claim	
14	Up-gradation to Business Class	-	-	-	300	300	300	500	500	750	750	1000	1000	Nil	
15	Lounge Access	-	Available	Available	Available	Available	Available	Available	Available	Available	Available	Available	Available	3 hours	
16	Home Burglary Insurance (in Indian Rs)	-	100000	100000	200000	200000	200000	300000	300000	300000	300000	500000	500000	first INR 10,000 of each claim	
17	Fire Cover for Building (Home in India)	-	-	-	-	-	-	-	INR 10,00,000	INR 10,00,000	INR 10,00,000	INR 20,00,000	INR 20,00,000	first 5% of each claim, minimum of INR 10,000	
18	Fire Cover for Contents (Home in India)	-	INR 1,00,000	INR 1,00,000	2,00,000	3,00,000	3,00,000	3,00,000	3,00,000	3,00,000	3,00,000	5,00,000	5,00,000	first 5% of each claim, minimum of INR 10,000	
19	Compassionate Visit	2000 USD	2000 USD	2000 USD	2000 USD	2000 USD	2000 USD	2000 USD	2000 USD	2000 USD	2000 USD	2000 USD	2000 USD	Nil	
20	Return of Minor Child	2000	3000	3000	4000	5000	5000	5000	6000	6000	6000	7000	7000	Nil	
21	Personal Liability	50000	100000	100000	200000	250000	250000	250000	300000	300000	300000	500000	500000	Nil	
22	Hijack Distress Allowance	-	50 per day	50 per day	75 per day (7 days max)	125 per day (7 days max)	125 per day (7 days max)	125 per day (7 days max)	150 per day (7 days max)	150 per day (7 days max)	150 per day (7 days max)	150 per day (7 days max)	150 per day (7 days max)	12 Hours	
23	Loss Of Passport	300	300	300	300	300	300	300	500	500	500	500	500	25	
24	Loss of International Driving License	-	-	100	100	100	100	100	100	100	100	100	100	-	
25	Fraudulent Charges (Payment Card Security)	-	-	-	-	-	-	500	1000	1000	1000	2000	2000	Nil	
26	Emergency Cash Assistance	-	Available	Available	Available	Available	Available	Available	Available	Available	Available	Available	Available	Nil	
27	Political Risk and Catastrophe Evacuation	-	-	-	2500	5000	5000	5000	7500	7500	7500	10000	10000	Nil	
28	Golfer's Hole in One	-	-	-	300	300	300	300	300	300	300	500	500	Nil	
29	Adventure Sports	-	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Nil	