

**INDUSIND HEALTHGAIN POLICY - 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**

IGICL Employee Name and Code

**Proposer Details (All the details are mandatory)**

Name of Proposer

Permanent Address:

City: State: Pin code:

Communication Address: Same as Permanent Address / Different from Permanent Address (specify below)

City: State: Pin code:

Contact Number Primary No.: Secondary No.:

E-mail Id\*

\*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 [IGI email address].

Date of Birth DD / MM / YYYY Nationality

Gender Male / Female / Other Marital Status Married / Single / Other

Maiden Name (if applicable)

Occupation Salaried / Self-Employed / Others, pls specify

Pan No.: (Mandatory) If not provided Form 60 required.) Aadhaar Number / Virtual ID (Please fill at least one)

GST Registration No.: (if applicable) CKYC No.:

I have read, understood and accepted all Terms and Conditions & hereby authorize IndusInd General Insurance Company Limited or any of its Agents and/ or third party(ies) / affiliates to contact me via SMS / Email / Phone / WhatsApp / Facebook or any other modes on my registered phone number over-riding my 'DND' registration to make welcome calls / SMS, service calls / SMS or any other commercial communication.



**Avail Zone B discount?**

- Yes: Discount of 20% shall apply. Copay of 20% shall apply if treatment is taken in Zone A:
- Delhi, New Delhi & NCR including Faridabad, Noida, Ghaziabad, Gurugram, Greater Noida, Meerut, Karnal, Bhiwadi, YEIDA city (Yamuna city), Gautam Buddha Nagar;
  - MMR (Mumbai Metropolitan Region) including Mumbai (Mumbai City district and Mumbai suburban district),
  - Navi Mumbai, Thane, Mira Road, Bhayandar, Panvel, Kalyan & Dombivali,
  - State of Gujarat,
  - Navi Mumbai, Thane, Mira Road, Bhayandar, Panvel, Kalyan & Dombivali,
  - State of Gujarat,
  - Kolkata Metropolitan Region including Kolkata, Howrah, Chandannagar, Baranagar, Barasat, Barrackpore, Bhatpara, Bidhannagar, Dum Dum, Garulia, and Halisahar
- No

Do you have an existing Health Insurance policy with us?	Yes / No	Policy No.
Do you have any other existing Insurance policy with us?	Yes / No	Policy No.
Are you an employee of IndusInd General Insurance Company (IGICL)?	Yes / No	Employee ID.
Are you an employee of Anil Dhirubhai Ambani Group (other than IGICL)?	Yes / No	Employee ID. Company name
Were you referred by an employee of IndusInd General Insurance Company (IGICL)?	Yes / No	Name Employee ID.
Please provide your work email ID to avail additional Discount <b>Note:</b> Discount availability is subject to eligibility and verification.		
Rural or Social Sector Category	ASHA worker / MGNREGA / None of the above	
Would you like to opt for Electronic Policy Issuance through an e-Insurance Account (eIA) of an Insurance Repository?	Yes / No	
If you have an eIA, please provide following details:		
1) Name of Insurance Repository	M/s NSDL Database Management Limited / M/s Karvy Insurance Repository Limited / M/s Central Insurance Repository Limited / M/s CAMS Repository Services Limited	
2) eIA No.		
3) Name as appearing in eIA		
If you do not have an eIA, would you like to open an account? (If Yes, please fill up Insurance Repository Application Form)	Yes / No	



### 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

Details/Particulars	Nominee 1	Nominee 2
Date of Birth (DD/MM/YYYY)		
Relationship with Proposer		
Present Address of the Nominee		
Permanent Address of the Nominee	If same as Present Address	If same as Present Address
Mobile No.		
Email ID		
Percentage Share for Claim Amount Payable		

### Bank Details of the Nominee

Name of the account holder		
Name of the bank		
Branch Bank		
Account no.		
Bank IFSC code		
Account Type	SB Account / Current Account / Others (please specify)	SB Account / Current Account / Others (please specify)

Note: If Nominee is a minor, please also provide Appointee details

Name of Appointee	Mobile No.	Email	Aadhaar Number / Virtual ID	Date of Birth (DD/MM/YYYY)	Relationship with Nominee	Address of Appointee
			XXXXXXXX			

### Policy Details

Cover Type	Individual / Floater
Policy Tenure	1 year / 2 years / 3 years / 4 years / 5 years
	Plus : 5
Plan & Base Sum Insured opted (in lakhs)	Power : 10 / 15 / 20 Prime : 25 / 30 / 50 / 100 / 300 / 500

### Optional Covers\*

Short Stay Treatment	Yes / No
Chronic Shield	Yes / No (If yes, please disclose the relevant Pre-existing Diseases in Insured Person's details)



<b>Enhanced Cover:</b> Guaranteed Cumulative Bonus, Consumable Cover	Option A / Option B / No		
Double Cover	Yes / No		
Change in Room Rent Limits	Yes / No If Yes, Category of Room will be capped to: Plus: Twin Sharing Power and Prime: Single Private A.C Room		
Reduction in PED Waiting Period Limit Required	24 months / 12 months / Not Required		
Voluntary Co-payment	10% / 20% / None		
Voluntary Aggregate Deductible	10000 / 25000 / 50000 / 100000 / None		
Hospital Cash	Daily Cash Amount: 1000 / 1500 / 2000 / 2500 / None		
<b>Convenience Cover:</b> Change in Pre-Post Hospitalization, Air Ambulance, Radio Taxi, Convalescence Cover	Yes / No		
<b>Smart Cover:</b> Vision Correction, Second Opinion	Yes / No		
<b>Family Care Cover:</b> Home Care Treatment, Companion Cover and Child Care Cover	Yes / No		
<b>Mother and Child Care:</b> Maternity Cover, Newborn Baby and Vaccination Cover, Infertility Cover	Option 1 (for SI 5 lakhs and 10 lakhs and above)	Option 2 (for SI 10 lakhs and above)	None

\*Optional Covers are available for S.I 5 lakhs and above except for Change in Room Rent limits and Voluntary Deductible

**Proposer Bank Details**

Name of Bank Account Holder \_\_\_\_\_

Bank Name: \_\_\_\_\_ Account Type: Savings / Current

Bank Account Number: \_\_\_\_\_ 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 bank): \_\_\_\_\_

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.

**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)				
Date of Birth	DD/MM/YYYY	DD/MM/YYYY	DD/MM/YYYY	DD/MM/YYYY
Relationship with Proposer				
Nationality	Indian / Other: Please specify	Indian / Other: Please specify	Indian / Other: Please specify	Indian / Other: Please specify



If not Indian, does the member hold an OCI card?	Yes / No	Yes / No	Yes / No	Yes / No
Country of Residence	Indian / Other: Please specify	Indian / Other: Please specify	Indian / Other: Please specify	Indian / Other: Please specify
ABHA Number or ABHA ID				
Aadhaar Number/Virtual ID				
Occupation				
Height (in cms.)				
Weight (in kgs.)				

**NRI Declaration:**

I am applying for this insurance under the Non-Resident Indian (NRI) category and I hereby declare that that the permanent residence of the members proposed above are and will be based outside geographical boundaries of India during the policy tenure.

Medical Questions	Member 1	Member 2	Member 3	Member 4
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)?	Yes / No	Yes / No	Yes / No	Yes / 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?	Yes / No	Yes / No	Yes / No	Yes / 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?	Yes / No	Yes / No	Yes / No	Yes / 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?	Yes / No	Yes / No	Yes / No	Yes / No
Was any person proposed to be insured diagnosed with any of these medical conditions with or without any follow-up tests/medications?				
• Asthma	Yes / No	Yes / No	Yes / No	Yes / No
• Diabetes	Yes / No	Yes / No	Yes / No	Yes / No
• Hypertension	Yes / No	Yes / No	Yes / No	Yes / No
• High Cholesterol or high triglycerides	Yes / No	Yes / No	Yes / No	Yes / No

• Hypothyroidism or Pituitary disorder	Yes / No	Yes / No	Yes / No	Yes / No
• Liver Cirrhosis	Yes / No	Yes / No	Yes / No	Yes / No
• HIV/AIDS	Yes / No	Yes / No	Yes / No	Yes / No
• 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 - dd/mm/yyyy	Yes / No Date of Delivery - dd/mm/yyyy	Yes / No Date of Delivery - dd/mm/yyyy	Yes / No 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	Yes / No	Yes / No	Yes / No	Yes / No
• Subject to Loading in premium due to health conditions or been made	Yes / No	Yes / No	Yes / No	Yes / No
• Subject to any special conditions by any insurance company	Yes / No	Yes / No	Yes / No	Yes / No

<b>PED Questions</b>	<b>Member 1</b>	<b>Member 2</b>	<b>Member 3</b>	<b>Member 4</b>
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?	Yes / No	Yes / No	Yes / No	Yes / 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?	Yes / No	Yes / No	Yes / No	Yes / No
Any sexually transmitted diseases including Syphilis, Gonorrhoea, Genital Herpes, Chlamydia?	Yes / No	Yes / No	Yes / No	Yes / No
Liver Cirrhosis, Alcoholic Liver disease, Oesophageal Varices and Fibrosis, Pancreatic Disease, Hepatitis B, Hepatitis C or any other disorder of the liver or pancreas, or Liver transplant?	Yes / No	Yes / No	Yes / No	Yes / No
Inflammatory Bowel Disease, Crohn's disease, Systemic Lupus Erythematosus or any other ailment of the digestive system?	Yes / No	Yes / No	Yes / No	Yes / No
Cancer, Leukemia, Papulosquamous disorder of skin, Tumor - malignant, or any growth or cyst anywhere in the body?	Yes / No	Yes / No	Yes / No	Yes / No
Rheumatoid arthritis, Avascular Necrosis, Ankylosing Spondylitis, Spinal Stenosis, Spondylosis, Multiple Sclerosis, Muscular Dystrophy or any other disorder of bone, muscles or joints?	Yes / No	Yes / No	Yes / No	Yes / No
Kidney transplant, Kidney/Renal Failure, Stone in urinary tract, Prostate disorder or any other kidney disorder whether or not requiring dialysis?	Yes / No	Yes / No	Yes / No	Yes / No

Stroke, Epilepsy (fits), Paralysis, Demyelinating disease, Alzheimers Disease, Parkinsons Disease or any other disorder of the brain, spinal cord or nervous system?	Yes / No	Yes / No	Yes / No	Yes / No
Severe Anemia, Hemophilia, Idopathic Thrombocytopenic Purpura, Thalassemia (major), Peripheral Vascular Disease, Deep Vein Thrombosis, Lymphoma or any other blood/ Lymphatic system disease or Sarcoidosis?	Yes / No	Yes / No	Yes / No	Yes / No
Diabetes with HbA1c >= 10 or fasting sugar above 250 , Hypertension with three medication or blood pressure above 180/100?	Yes / No	Yes / No	Yes / No	Yes / No
Cerebral Palsy, any internal deformity or sickness from birth / early childhood?	Yes / No	Yes / No	Yes / No	Yes / No
Loss of Hearing	Yes / No	Yes / No	Yes / No	Yes / No
Diseases of the Ear/Nose/Throat/Teeth/ Eye (please mention Diopters in case of refractory error)?	Yes / No	Yes / No	Yes / No	Yes / No
Detoxication therapy for alcohol, narcotics, or any other habit-forming drugs?	Yes / No	Yes / No	Yes / No	Yes / No
Any other Illness/Injury: Please Specify				
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	1. Name of Disease/ condition 2. Since: dd/mm/yyyy	1. Name of Disease/ condition 2. Since: dd/mm/yyyy	1. Name of Disease/ condition 2. Since: dd/mm/yyyy

### Lifestyle Questions

Does any of the persons proposed to be insured use tobacco products/cigarettes or drink alcohol?	Yes / No	Yes / No	Yes / No	Yes / 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?	Yes / No	Yes / No	Yes / No	Yes / No

**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.

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.

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

### Section B: Existing Health - Insurance details

Details	Member 1	Member 2	Member 3	Member 4
Name of Insurer				
Policy no.				
Policy Period				
From DD / MM / YYYY				
To : DD / MM / YYYY				
Sum Insured (Rs.)				



Cumulative Bonus, if any				
Type of Cover	Individual / Floater	Individual / Floater	Individual / Floater	Individual / Floater
Have any of the persons to be insured ever filed a claim with their current/previous insurer? If yes, please provide details on a separate sheet	Yes / No	Yes / No	Yes / No	Yes / No
Has any proposal of life, critical or health insurance been declined, cancelled or charged a higher premium?	Yes / No	Yes / No	Yes / No	Yes / No
Are any of the persons proposed for insurance covered under any other health insurance policy with the Company?	Yes / No	Yes / No	Yes / No	Yes / No

Are you applying for portability of the above policy? Y / N (If yes, please fill in the separate Portability Form).

If you choose 'No, and continue the above existing policy along with IndusInd HealthGain, the proposal shall be eligible to get a concurrent policy discount on premium.

<b>Attending Physician's Detail</b>			
<b>Name of Family Physician:</b>	(Title)	(First Name)	(Last Name)
Contact Number:		E-mail ID:	
<b>Premium Payment Details</b>			
<b>Payment frequency:</b>	Lumpsum / Half-yearly / Quarterly / Monthly		
<b>To Be printed as made available</b>	3 EMIs / 6 EMIs / 12 EMIs# #For Long Term Policies only		
<b>Payment by:</b>	Cheque / DD / Credit Card / Debit Card / NEFT / Net Banking		
<b>Cheque or DD amount in figures:</b>	₹	<b>Cheque/DD Date:</b>	DD / MM / YYYY
<b>Cheque or DD amount in words:</b>	₹		
<b>Cheque/DD/Card No:</b>			
<b>Bank Name:</b>			
<b>Name of Premium Payer:</b>			
<b>Note:</b> 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			
<input type="checkbox"/> Activate Auto-debit for easy premium payment and avail corresponding discount for the same.			
By ticking this option I authorize IndusInd General Insurance Company Limited to auto-debit instalment or renewal premium for the policy issued against this proposal form for ____ years. I understand and agree that the renewal would be effective subject to receipt of applicable premium before the due date. The premium applicable would be as per age and premium rates on the due date of renewal.			
(Please fill the attached Mandate Form for Auto-pay (NACH / ECS / Direct Debit) form for instalment/ renewal premium payment through standing instruction)			



### 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. Ayushman Bharat Health Account (ABHA) Declaration: I on behalf of all person(s) to be insured provide consent to provide access to the medical and personal records/details of all person(s) to be insured, as are available in my/ our Ayushman Bharat Health Account (ABHA) and share the same with Third Party Administrators, Reinsurer (if applicable), Service Provider(s) of the Company and/or with any Governmental and/or Regulatory authority for the sole purposes of underwriting my/ our proposal and/ or for checking the authenticity of claims lodged by me/ us and/ or to comply with the applicable Law and Regulations.
- vi. 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

### 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.
- 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

### 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

- 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.
- I Understand that the Company has the right to call for document to established sources of funds
- 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.

Proposer's Signature *	Date	Place	Time
Verified by providing OTP number sent to registered mobile no. (xxxxxxxxxxxxx) at (HH:MM:SS) on DD-MM-YYYY and confirmed at (HH:MM:SS) on DD-MM-YYYY			

\*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.



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022 4890 3009 (Paid)



74004 22200 (WhatsApp)

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**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.

**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: DD/MM/YYYY

Signature/Thumb impression of (Proposer)

**Explained By Intermediary (Name):**

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

Date: DD/MM/YYYY

Signature of Intermediary

**DECLARATION FOR PERSONS WITH DISABILITY**

(Note: The below must be witnessed by someone other than the Advisor/Intermediary/Employee of the Company)

I certify that the replies in the Proposal Form have been recorded as per the information provided by me. I, (Full name of the representative) \_\_\_\_\_ (Relationship with the Proposer) \_\_\_\_\_, adult and inhabitant of (City) \_\_\_\_\_ 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 Company Limited, to the Proposer and they have understood the same. I declare that the facts stated herein are true and correct to the best of my knowledge and belief.

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

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

Signature of Authorized Person

Signature of

Intermediary

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

[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/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 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 General Insurance Company Limited. The content of this form and its particulars have



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022 4890 3009 (Paid)



74004 22200 (WhatsApp)

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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.

Agent / Intermediary Name:	Agent / Intermediary Code:	License No.:
Signature of Agent / Intermediary:	Date:	Place:
[Display 'Confirmed' when ticked]		

**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 ten lakh rupees.

**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 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 \_\_\_\_\_



## ANNEXURE ATTACHED TO THE PROPOSAL FORM

### Plan 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.

<b>Proposer Details (All the details are mandatory)</b>						
Policy Period	1 year, 2 years, 3 years, 4 years and 5 years					
Plan Type	There are 3 plans Plus, Power, Prime					
New Business Base Sum Insured (in lakhs)	Plus: 5 Power: 10,15,20 Prime: 25,30,50,100, 300, 500					
Renewal Business/ Call Option Base Sum Insured (in lakhs)	Plus: 3,5, 6,9 Power: 10,12,15,18,20,24, Prime: 25,30,36, 40,48,50,60,72,80,100, 300, 500					
Room Category	For Plus: Single Private Air-Conditioned Room For Power and Prime: Actuals					
Benefit No.	Covers	Limits for Plus	Limits for Power	Limits for Prime	Basis of Payment	Pre-Requisite for Claim
<b>Benefit 3.1 :- Hospitalization Covers:</b>						
3.1.1	Hospitalization Expenses:	Upto the Sum Insured			Indemnity	Not applicable
3.1.1.1	In Patient Treatment	Within the Sum Insured			Indemnity	Not applicable
3.1.1.2	Day Care Treatment	Within the Sum Insured			Indemnity	Not applicable
3.1.1.3	Accommodation Bonus	<b>Accommodation Bonus:</b> Additional fixed daily amount of Rs 1000 for opting Twin-sharing room category or lower			Benefit	3.1.1.1 - In Patient Treatment
3.1.3	Domestic Road Ambulance	upto 1500 per hospitalization	Actuals		Indemnity	3.1.1.1 - In Patient Treatment
		Intercity Ambulance cost (beyond 100km): upto Rs 20000 per hospitalization	(Including Intercity ambulance cost: beyond 100km)			
3.1.4	Domiciliary Hospitalization	Within the Sum Insured			Indemnity	Not applicable
3.1.5	Modern Treatment	upto 100% of Base Sum Insured			Indemnity	3.1.1 - Hospitalization Expenses or 3.1.3 - Domiciliary Hospitalization
3.1.6	Pre Hospitalization	upto 60 days, within the Sum Insured			Indemnity	3.1.1 - Hospitalization Expenses, 3.1.3 - Domiciliary Hospitalization
3.1.7	Post Hospitalization	upto 90 days, within the Sum Insured			Indemnity	3.1.1 - Hospitalization Expenses, 3.1.3 - Domiciliary Hospitalization
3.1.8	Organ Donor Expenses	Upto Sum Insured, including Pre and Post Hospitalization Expenses			Indemnity	3.1.1.1 - In Patient Treatment
		Within Sum Insured				



<b>Benefit - 3.2: Extra Cover</b>					
3.2.1	Unlimited Reinstatement of Base Sum Insured	On subsequent claim, Unlimited reinstatement of Base Sum Insured on related and unrelated illness or injury.		Indemnity	3.1-Hospitalization Cover, 3.7.1 Short Stay Treatment
3.2.2	Extra Sum Insured	Additional,20% of Base Sum Insured on same claim, in single Hospitalization		Indemnity	3.1-Hospitalization Cover, 3.7.1 Short Stay Treatment
<b>Benefit - 3.3 - Personal Accident Cover</b>					
3.3.1	Accidental Death Cover	Not Applicable	5% of Base Sum Insured subject to minimum of Rs 1lakh	Benefit	Not applicable
<b>Benefit - 3.4 - Critical Illness Cover</b>					
3.4.1	Waiver of Premium	Not Applicable	Waives off renewal Policy Premium on diagnosis of listed Critical Illness	Not Applicable	Not applicable
<b>Benefit - 3.5 - Renewal Benefits</b>					
3.5.1	Cumulative Bonus	33.33% increase in Base Sum Insured for every claim-free Policy Year, max upto 100% of Base Sum Insured and 33.33% decrease for every claim year		Indemnity	3.1 - Hospitalization Cover, 3.7.1 Short Stay Treatment
3.5.2	Call Option for Enhancement of Base Sum Insured	After 4 continuous and consecutive claim free Policy Years, if Policyholder avails this benefit then enhanced Sum Insured is sum of expiring Policy's Base Sum Insured and accumulated Cumulative Bonus		Indemnity	3.1 - Hospitalization Cover, 3.7.1 Short Stay Treatment
3.5.3	Loyalty Cover	Accidental Death, Permanent Total Disability, Critical Illness, Hospital Cash,  Leave compensation Benefit Please refer table below for details**		Benefit and Indemnity	3.1.1.1 - In Patient Treatment (applicable for Hospital Cash and Leave Compensation benefit)
3.5.4	No Claim Discount	No Claim Discount of Rs. 50 at the end of each completed and continuous Policy Year, provided that no Claim has been made in the expiring Policy Year.		Indemnity	3.1 - Hospitalization Cover, 3.7.1 Short Stay Treatment
<b>Benefit - 3.6 - Value Added Covers</b>					
3.6.1	Wellness Services	Medical advice through telephonic or online mode		Not Applicable	Not applicable
3.6.2	Claim Service Guarantee	Cashless Claim - 1% of Delayed Claim Amount (for delay beyond 3 hours to 6 hours), additional 1% for every additional delay of 3 business hours Reimbursement Claim-1% of Delayed Claim Amount (for delay beyond 15 days to upto 21 days), additional 1% for every additional delay of 15 days Maximum limit - 6% of Delayed Claim Amount		Indemnity	3.1.1 Hospitalization Expenses
3.6.3	Policy Pause	Policy Pause of minimum continuous period of 7 days and maximum continuous period of up to 90 days in a Policy Year during travel outside of India; and corresponding renewal discount equivalent to the Pro-rated expiring Policy premium.		Indemnity	Not applicable
3.6.4	Spouse First Cover	Continuity benefit for listed waiting periods served by Insured shall be credited to the newly wedded spouse		Indemnity	Not applicable
<b>Benefit - 3.6.5 - Preventive Care Covers</b>					
3.6.5.1	Health Check-up	3000(Annual, From Day 1)		Indemnity	Not applicable
3.6.5.2	Vaccination Cover	3500 (Annual, From Day 1)		Indemnity	Not applicable

**Benefit - 3.7 - Optional Covers\***

3.7.1	Short Stay Treatment	Provides coverage towards admission to Hospital for minimum of 2 hours during the Policy Year (Within the Sum Insured)	Indemnity	Not applicable
3.7.2	Chronic Shield	Day 31 cover for the below listed chronic conditions (only if declared and accepted). i. Asthma ii. Hypertension (Blood Pressure) iii. Hyperlipidaemia (Cholesterol) iv. Diabetes Mellitus	Indemnity	3.1.1 Hospitalization Expenses, 3.7.1 Short Stay Treatment

**Benefit - 3.7.3 - Enhanced covers (Bundle)**

3.7.3.1	Guaranteed Cumulative Bonus	Option A: This benefit waives off the condition of decrease in Cumulative Bonus in case of a claim in immediate previous Policy Year  Option B: Benefit 3.5.1 Cumulative Bonus shall be upgraded as follows: 100% increase in Base Sum Insured for every claim-free Policy Year, max upto 300% of Base Sum Insured. This also waives off the condition of decrease in Cumulative Bonus in case of a claim in immediate previous Policy Year.	Indemnity	3.1 - Hospitalization Cover, 3.7.1 Short Stay Treatment	
3.7.3.2	Consumable Cover	Within Sum Insured  List I, II, III, IV mentioned in Annexure A shall be covered up to Sum insured	Indemnity	3.1 - Hospitalization Cover, 3.2 - Extra Cover, 3.5 - Renewal Benefits, 3.7.1 - Enhanced Covers (if applicable), 3.7.2 - Double Cover, 3.7.10 - Smart Covers, 3.7.1 Short Stay Treatment	
3.7.4	Double Cover	Additional,100% of Base Sum Insured for Same claim. This benefit supersedes-Benefit no-3.2.2 Extra Sum Insured	Indemnity	3.1-Hospitalization Cover	
3.7.5	Change in Room Rent limits	Category of Room capped to: Twin sharing	Category of Room capped to: Single Private A.C room	Indemnity	3.1.1 Hospitalization Expenses, 3.7.1 Short Stay Treatment
3.7.6	Reduction in Pre-Existing Waiting Period	This benefit reduces the Pre-Existing Waiting Period to 24 months or 12 months	Not Applicable	3.1 - Hospitalization Cover, 3.7.1 Short Stay Treatment	
3.7.7	Voluntary Aggregate Deductible	Options are:10000,25000,50000,100000	Indemnity	3.1 - Hospitalization Cover, 3.7.1 Short Stay Treatment	
3.7.8	Voluntary Co-payment	10% / 20% on the Assessed Claim Amount	Indemnity	3.1 - Hospitalization Cover, 3.7.1 Short Stay Treatment	
3.7.9	Hospital Cash	Daily Cash options:1000,1500,2000,2500 max up to 30 days for In Patient Hospitalization and 15 days for ICU Hospitalization Minimum Hospitalization of 72 hours	Benefit	3.1.1.1 - In Patient Treatment	

**Benefit - 3.7.10 - Convenience Cover (Bundle)**

3.7.10.1	Change in Pre-Post Hospitalization limit	Upgrade of Pre-Hospitalization to 90 days Upgrade of Post Hospitalization to 180 days	Indemnity	3.1.1 - Hospitalization Expenses, 3.1.3 - Domiciliary Hospitalization or 3.1.4 - Modern Treatment
3.7.10.2	Air Ambulance	75% of Base Sum Insured or Rs 5 Lakhs whichever is higher	Indemnity	3.1.1.1 - In Patient Treatment
3.7.10.3	Radio Taxi	1000 per Hospitalization	Indemnity	3.1.1.1 - In Patient Treatment

3.7.10.4	Convalescence Cover	Lumpsum amount of Rs.10000 if hospitalized for a minimum period of 7 continuous and consecutive days	Lumpsum amount of Rs.25000 if hospitalized for a minimum period of 7 continuous and consecutive days	Benefit	3.1.11 - In Patient Treatment												
<b>Benefit - 3.7.11 - Smart Covers (Bundle)</b>																	
3.7.11.1	Vision Correction	50000 (Within Sum Insured)	100000 (Within Sum Insured)	Indemnity	3.1.1 - Hospitalization Expenses												
3.7.11.2	Second Opinion	5000 (Within Sum Insured)		Indemnity	Not applicable												
<b>Benefit - 3.7.12 - Family Care Cover (Bundle)</b>																	
3.7.12.1	Home Care Treatment	Within Sum Insured		Indemnity	Not applicable												
3.7.12.2	Companion Cover	Per day Daily Cash:1000, max up to 30 days Minimum Hospitalization of 72 hours		Benefit	3.1.11 - In Patient Treatment												
3.7.12.3	Child Care Cover	Per day Daily Cash:1000, max up to 30 days Minimum Hospitalization of 72 hours		Benefit	3.1.11 - In Patient Treatment												
<b>Benefit - 3.7.13 - Mother and Child Care (Bundle)</b>																	
3.7.13.1	Maternity Cover	<table border="1"> <thead> <tr> <th>Sum Insured</th> <th>Maternity Limit* (Normal and C - Section)</th> </tr> </thead> <tbody> <tr> <td>5 lakhs</td> <td>1 lakh</td> </tr> <tr> <td>&gt;=10lakhs</td> <td>Option 1- 1 lakh Option 2- 2 lakhs</td> </tr> </tbody> </table> <table border="1"> <thead> <tr> <th>Policy Tenure</th> <th>Waiting period</th> </tr> </thead> <tbody> <tr> <td>1 and 2 years</td> <td>24 months</td> </tr> <tr> <td>3 years or more</td> <td>Option 1: Zero Option 2: 12 months Option 3: 24 months</td> </tr> </tbody> </table>		Sum Insured	Maternity Limit* (Normal and C - Section)	5 lakhs	1 lakh	>=10lakhs	Option 1- 1 lakh Option 2- 2 lakhs	Policy Tenure	Waiting period	1 and 2 years	24 months	3 years or more	Option 1: Zero Option 2: 12 months Option 3: 24 months	Indemnity	Not applicable
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3.7.13.2	Newborn Baby and Vaccination Cover	Within the Maternity Limit		Indemnity	3.7.12.1 Maternity Cover												
3.7.13.3	Infertility Cover	<p>Within the Maternity Limit;</p> <ul style="list-style-type: none"> <li>subject to Waiting period as follows</li> </ul> <table border="1"> <thead> <tr> <th>Maternity Waiting period opted</th> <th>Infertility Cover Waiting Period</th> </tr> </thead> <tbody> <tr> <td>Zero</td> <td>12 months</td> </tr> <tr> <td>12 months</td> <td>12 months</td> </tr> <tr> <td>24 months</td> <td>24 months</td> </tr> </tbody> </table> <ul style="list-style-type: none"> <li>No of cycles covered: 2</li> </ul>		Maternity Waiting period opted	Infertility Cover Waiting Period	Zero	12 months	12 months	12 months	24 months	24 months	Indemnity	Not applicable				
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**Notes:**

- i. Optional Covers are available for Sum Insured Rs 5 lakhs and above except for Benefit no.3.7.5 Change in Room Rent Limits, Benefit no-3.7.7 Voluntary Aggregate Deductible and 3.7.8 Voluntary Co-payment
- ii. The maximum liability of the Company to pay the claims under this Policy is limited to Total Liability defined under the Policy.
- iii. Non-Resident Indian (NRI) Insured persons shall not be eligible for Benefit – 3.6.4 Policy pause cover.
- iv. Benefit no-3.7.7 Voluntary Aggregate Deductible and 3.7.8 Voluntary Co-payment cannot be opted together.
- v. Benefit no-3.7.7 Voluntary Aggregate Deductible and Benefit no- 3.7.13 Mother and Child Care cannot be opted together. 3.7.8 Voluntary Co-payment and Benefit no- 3.7.13 Mother and Child Care cannot be opted together.
- vi. Benefit no- 3.7.2 Chronic Shield and Benefit 3.7.6 Reduction in Pre-Existing Waiting Period cannot be opted together.
- vii. Benefit no- 3.7.2 Chronic Shield shall not be available to the children. The cover shall not be available to persons whose age at the time of inception of the first Policy is  $\geq 61$  years.
- viii. Benefit no- 3.7.13 Mother and Child Care shall be available only when both self and spouse are covered under the Policy.

**\*\*Loyalty Cover**

Availability under Loyalty Cover							
Policy Year	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7 onward	Maximum limit
<b>Accidental Death and Permanent Total Disability</b>	10% of Base Sum Insured	20% of Base Sum Insured	30% of Base Sum Insured	40% of Base Sum Insured	50% of Base Sum Insured	50% of Base Sum Insured	50% of Base Sum Insured or 25 lakhs, whichever is lower
<b>Critical Illness</b>		10% of Base Sum Insured	20% of Base Sum Insured	30% of Base Sum Insured	40% of Base Sum Insured	50% of Base Sum Insured	50% of Base Sum Insured or 25 lakhs, whichever is lower
<b>Hospital Cash</b>			Daily Cash amount (Plan wise) of: Plus: Rs. 1000, Power: Rs. 2000, Prime: Rs. 3000	Daily Cash amount (Plan wise) of: Plus: Rs. 1000, Power: Rs. 2000, Prime: Rs. 3000	Daily Cash amount (Plan wise) of: Plus: Rs. 1000, Power: Rs. 2000, Prime: Rs. 3000	Daily Cash amount (Plan wise) of: Plus: Rs. 1000, Power: Rs. 2000, Prime: Rs. 3000	30 days of payment
<b>Leave Compensation Benefit</b>				Rs. 1000 per day	Rs. 1000 per day	Rs. 1000 per day	30 days of payment

