

SHRI HEALTH SURAKSHA INSURANCE POLICY: PROPOSAL FORM

INTERMEDIARY DETAILS:					
Branch Code:		Employee Code:		Intermediary Code:	
Aadhar No:		Pan No:		Contact No.	
Proposal For:	New Policy []	Endorsement []	Renewal of SGI []	Renewal of others []	
PROPOSER DETAILS:					
Do you have CKYC Number?			Yes/No.....		
If Yes Please enter the CKYC Number					
If no, please tick enter any of the following ID No. and attached the same. Pan/Voter ID/Driving Licence / Aadhaar no/Any other ID No.					
If you have an e-Insurance Account (eIA) number, kindly provide e-Insurance Account (eIA) number					
I confirm that there is no change in my existing KYC details. In case any change in my KYC details, I undertake to inform you in writing.					
Name:					
Rental/Current Address:					
City:		State:		Pin code:	
Permanent Address:					
City:		State:		Pin code:	
Contact Details:					
Mobile No:			Email ID:		
Date of Birth: ____/____/____			Education Qualification:		
Marital Status:		Married []	Single []	Divorced []	Widowed []
Occupation	Business []	Professional []	Govt. Employee []	Defence Professional []	Other []
Gender	Male (M) []		Female(F) []		Third Gender (TG) []
Select the Policy Term	1 Year : []		2 Year : []		3 Year : []
Policy Term	From ____/____/____			To ____/____/____	
Policy Type	Individual []	Floater []	Floater Sum insured:		Total No. of Members:
Do you want Cumulative Bonus or Renewal Discount if there is no claim in expiring policy:			Cumulative [] Bonus		Renewal [] Discount
Policy Sum insured is available Rs. 50,000 to 10 lakhs in step of 50,000 and 15L, 20L, 25L,50L,1Cr.					
Optional Cover – you can opt below covers on payment of additional premium					
Covers	Benefit Details				Yes/No
1. Pre /Post Hospitalization	60/90 Days				
2. Room Capping	Up to 2% of the sum insured subject to maximum of Rs.10000/-, per day				
3. ICU Capping	Up to 5% of the sum insured subject to maximum of Rs.20,000/- per day				
4. Co-Pay Waiver	5% co-payment not applicable on Claim				
5. Single AC Room	Up to the Policy Sum Insured				
6. ICU – No Limit	Up to the Policy Sum Insured				
7. Restoration Benefit	Upon complete exhaustion of the Sum Insured and Cumulative Bonus Sum Insured will restore unlimited times subject to maximum 100% of Sum Insured each time for unrelated disease				
8. Bonus Boost	Inbuilt cumulative bonus will be replaced with Bonus Boost benefit where Sum insured will increase by 25% of SI in respect of each claim free year of insurance maximum up to 250% of SI. In the event of claims the Bonus Boost shall be reduced at same rate.				
9. Consumables Waiver	Pay for expenses incurred on consumables as specified in List -1 of Annexure – I Policy wording				
10. Ambulance Plus	Up to the Policy Sum Insured				

11.	Pre-Existing Disease Waiting Period Reduction					
Note: You can opt either of 2 or 5 and 3 or 6 but cannot be opted together						
DETAILS OF PERSONS TO BE INSURED						
Details	Insured 1	Insured 2	Insured 3	Insured 4	Insured 5	Insured 6
Member Name						
Is Shriram employee (Y/N)						
Sum Insured (not applicable for Floater Type)						
Date of Birth(dd/mm/yy)						
Age						
Gender (M/F/TG)						
Height(cm)						
Weight(kg)						
Occupation						
Nationality						
Marital Status						
Relationship with Proposer						
Name the Pre-existing disease/s if any						
ABHA Number 14 digits						
Has any of your proposal for health insurance been declined, cancelled, charged a higher premium or issued with special conditions						
Are you a Politically Exposed Person (PEP) or family member/ close relative / associate of PEP write Yes or No						
Note: Politically Exposed Persons” (PEPs) are individuals who have been entrusted with prominent public functions by a foreign country, including the heads of States or Governments, senior politicians, senior government or judicial or military officers, senior executives of state-owned corporations and important political party officials						
Nominee Details						
Nominee Name						
Age of Nominee						
Relation with Nominee						
% of Nominee share						
Appointee Name if nominee is minor						
Age of Appointee						
Relation with Appointee						
Bank Details of Nominee						
Bank Name						
Account No						
IFSC Code						

Provide the details of Existing or Previous Health Insurance policy with SGI or/and any other company.						
Name of the Insurance Company						
Period of Insurance						
Sum Insured (Rs)						
Policy No.						
Ailment for which Claim was made						
Claim Amount Paid / Rejected						
Has the person proposed for insurance ever suffered or suffering from any of the following						
Diabetes Mellitus - If Yes, since when						
High BP, Cholesterol - If Yes, since when						
Heart Disease - If Yes, since when						
Stroke, epilepsy, fainting attack, chronic headache, Parkinson's disease, Alzheimer's disease, - If Yes since when						
Tuberculosis, asthma, other respiratory infections - If Yes, since when						
Disease of bones/joints, slipped disc, spinal disorder, injury to ligaments - If Yes, since when						
Cancer, Pre-Cancerous Lesion - If Yes, since when						
Gynecological disorder such as DUB, Fibroid Uterus, Ovarian cyst - or have undergone cesarean / Hysterectomy If Yes, since when						
Treatment for sub fertility or has been advised for? (answer if applicable) – If Yes provide details						
Disease of Stomach, Intestine, Liver, Gall bladder / Pancreas, Kidney, Urinary bladder, Urinary Tract Diseases - If Yes, since when						
Disease of Prostrate / Fistula / Piles / Genital diseases - If Yes, since when						
Cataract and other diseases of the eye and ENT disease - If Yes since when						
Any Other Disease /health adversity / injury / condition /ailment not mentioned above (Please Specify)						
Any hospitalization for illness or any surgery in past						

Are you taking any medicine currently or in last three month (Please Specify)						
Does the person propose for insurance						
Chew Tobacco - If Yes, since when and specify number of pouches per day						
Smoke - If Yes, since when and specify no. of consumption per day						
Consume Alcohol - If Yes, since when and please specify number of ml per week						
Has the person/s proposed for insurance						
Undergone any medical test?						
Been advised for any surgery / treatment? - If Yes, give details						
Received /receiving any payment for any disability / injury / illness/ disease. Give details						
Is the person proposed for insurance positive for HIV If yes, please mention your CD4count (Please attach proof						
Has any proposal for your health insurance ever been declined, postponed, withdrawn or accepted at an increased premium or with special terms or conditions.						
Do You Want Physical Policy Wording Copy (YES/NO) :						
Premium (₹)						
Net Premium:	Tax:	Total Premium:				
Do you want to pay the premium in Instalments: Yes / No?						
• If yes choose Instalment options: Monthly ☐ Quarterly ☐ Half-Yearly ☐ Annually ☐						
Payment Details						
Cheque ☐ DD ☐ Cash ☐ Pay Order ☐ Bima ASBA ☐ UPI ID						
Any Other (Please Specify)						
Amount (Rs.) /-Amount in Words (Rupees).....						
Bank Name: Cheque/DD Date						
Bima-ASBA Consent (Bima-Applications Supported By Blocked Amount)						
I give my consent to Shriram General Insurance Co. Ltd. to temporarily block the premium amount of Rs. _____ for Shri Health Suraksha Insurance proposal under the BIMA ASBA facility. If proposal is approved, the amount will be deducted from my bank account. If not, only medical examination charges (if any) will be deducted, and the remaining amount will be released back to my bank account. Yes /No.....						
NEFT Payment Details (for Claim Disbursement)						
Payee Name:.....Bank A/c No.:.....Bank A/c Type:						
Bank name:.....Branch:.....IFSC Code:.....						

AML GUIDELINES

1. I/We hereby confirm that all premiums have/will be paid from bona fide sources and no premium have/will be paid out of proceeds of crime related to any of the offence as listed under Prevention of Money Laundering Act, 2002 including amendments thereafter.
2. I understand that the company has the right to call for documents to establish the sources of funds.
3. The insurance company has the right to cancel the insurance contract in case I am/have been found guilty by any competent court of law under any of the statutes, directly or indirectly governing the Prevention of Money laundering in India.
4. Nationality: ☐ Indian ☐ Non-Indian If Non-Indian, please specify the country _____
5. PAN Card Number _____
6. Any other _____

CKYC DECLARATION

1. I hereby give consent to Shriram General Insurance Company Limited to verify and obtain my information through Central KYC Registry or UIDAI or through any other modes for the purpose of undertaking KYC
2. I hereby declare that the details furnished above are true and correct to the best of my knowledge/belief and I undertake to inform you in writing with the copy of updated documents in case of any change in my KYC details.

DECLARATION

1. 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/ We am/ are authorized to propose on behalf of these other persons
2. I/We understand that the information provided by me/us will form the basis of Insurance Policy, and the proposal is subject to the Board approved underwriting policy of the Company and that the Policy will come into force only after Company's full receipt and realization of the premium chargeable.
3. I/ We further declare that I/We will notify in writing any change occurring in the occupation or general health of the Insured Person(s) to be insured/ proposer after the proposal has been submitted but before communication of the risk acceptance by the Company. Upon renewal of Policy, I/We agree to abide by the standard Terms and Conditions, unless otherwise mentioned by the Company in renewal Policy Schedule or attachments thereto.
4. I/ We declare and consent to the company seeking medical information from any doctor or from a hospital/institution who at any time has attended on the Proposer/Insured Person to be insured 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 settlement.
5. I/ We declare and provide my unconditional consent that, pursuant to a claim filed by me/ us, the Insurance Company can seek medical and other relevant information/ documents for me/ us from any Doctor and/ or Hospital where I, or other Insured, had taken treatment i.e. OPD and/ or hospitalization etc.
6. I/We authorize the Insurance Company to share information pertaining to my proposal, including the medical records for the sole purpose of underwriting and/ or claims.
7. I/ We authorize the Company to process my/ our Personal information for profiling purposes and contact me/ us for
 - (i) communicating for renewal of the Policy,
 - (ii) upsell and/ or cross sale of other insurance products.
8. I/ We authorize the Insurance Company to share my/ our Personal Information and other relevant records details with
 - (i) the Law Enforcement Agencies, as and when demanded and
 - (ii) any other vendor as per the requirement etc. like printing the Insurance policy/ renewal reminders or any other such activity.
9. I/ We authorize the Insurance Company to share my/ our Personal Information and/ or medical Information/ records with any Government and/ or Statutory authorities/ bodies, including but not limited to Insurance Regulatory and Development Authority of India (IRDAI), Insurance Information Bureau (IIB) and/ General Insurance Council etc.
10. Customer Satisfaction Surveys: I/ We hereby consent to the Insurance Company to use and share my/ our Personal Information with the vendors for the purpose of conducting customer satisfaction surveys and related activities aimed at improving service quality and enhancing the overall customer experience.
11. Ayushman Bharat Health Account (ABHA) Declaration : I/We provide my/ our consent to access my/ our (all insured) medical and personal records/ details, 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 Shriram General Insurance Co. Ltd 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/ Regulations.
12. I/We hereby consent that, in any of the above scenarios, my/ our Personal Information and the medical documents etc. can be shared, and/ or accessed, as the case may be, without any intimation to me/ us.
13. I hereby grant consent to Agent/Broker/Corporate Agent or any other licensed intermediary to share my KYC (Know your Customer) and customer due diligence information with Shriram General Insurance Co. Ltd. for the purpose of my insurance proposal.

Date ____ / ____ / ____
Place: _____

Signature/ Thumb Impression of the Proposer _____

INTERMEDIARY DECLARATION

I, _____ (Full Name) in my capacity as an Insurance Advisor/ Specified Person of the Corporate Agent/Intermediary/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 here in 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 favor 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.

Date ____ / ____ / ____

Place: _____

Signature of the Intermediary

PROHIBITION OF REBATES – SECTION 41 OF THE 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.

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/Primary insured) _____ 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 Shriram General Insurance Company Ltd., to the Proposer/Primary Insured 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.

Date:

Place:

Signature of Witness

Signature of Proposer