

Proposal Form No.: _____

Date of Proposal and Declaration: _____

CORONA KAVACH POLICY, INDUSIND GENERAL - PROPOSAL FORM
Please note:

- To be filled and signed by Proposer and all fields are mandatory to be filled.
- This Proposal shall be the basis of contract for Policy issuance and the information declared in this form shall be used by the Company as the basis of underwriting the Policy.
- IndusInd General Insurance Company Limited (the "Company") is under no obligation to accept any proposal for insurance. The liability of the Company commences only when this proposal is accepted by the Company and the premium is received. If the Company accepts a proposal for insurance, it shall be subject to Policy Terms and Conditions.
- To be filled IN BLOCK LETTERS

1. INTERMEDIARY DETAILS

Intermediary Name			
Intermediary Code		IMD Employee Code	
IMD Branch Name		IMD Branch Code	

2. PROPOSER DETAILS (All the details are mandatory)

Name of Proposer	☐ Mr. ☐ Ms. ☐ Mrs. F I R S T M I D D L E L A S T		
Permanent Address:			
Flat / Building:		City:	
State:		Pin Code:	
Communication Address:			
Flat / Building:		City:	
State:		Pin Code:	
Contact Number	Primary No.:	Secondary No.:	
Email ID			
Date of Birth	DD / MM / YYYY	Nationality	
Gender	☐ Male ☐ Female	Marital Status	☐ Married ☐ Single ☐ Other
Maiden Name (if applicable)			
Occupation	☐ Salaried ☐ Self-Employed ☐ Others, pls specify _____		
Monthly Income	☐ Upto ₹ 20000 ☐ ₹ 20001 to ₹ 50000 ☐ ₹ 50001 to ₹ 100000 ☐ ₹ 100000 & above		
Source of Funds	☐ Business ☐ Profession ☐ Salary ☐ Agricultural Income ☐ Savings ☐ Other		
Pan No.		Aadhar No.	(Please fill at least one)
GST Registration Number	(if applicable)		


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3. POLICY DETAILS

Sum Insured:	☐ 50000 ☐ 100000 ☐ 150000 ☐ 200000 ☐ 250000 ☐ 300000 ☐ 350000 ☐ 400000 ☐ 450000 ☐ 500000				
Policy Period	☐ 3 ½ months ☐ 6 ½ months ☐ 9½ months				
Policy Start Date:	DD / MM / YYYY	Product Type:	☐ Individual ☐ Floater		
Do you want to buy Hospital Daily Cash(optional cover)?		☐ Yes ☐ No			

4. COVER 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.

Covers	Description
1. COVID Cover	Medical Expenses of Hospitalization for Covid for a minimum period of 24 consecutive hours only shall be admissible upto the Sum Insured limits
2. Home Care Treatment	Covers costs of treatment incurred by the Insured person on availing treatment at home for Covid on Positive diagnosis, maximum up to 14 days per incident
3. AYUSH Treatment	Covers medical expenses incurred for Inpatient Care treatment for Covid under Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homeopathy systems of medicines shall be covered upto Sum Insured, during the Policy Period
4. Pre-Hospitalisation	Covers medical expenses upto 15days prior to the date of hospitalization/home care treatment
5. Post-Hospitalisation	Covers medical expenses upto 30days from the date of discharge from the hospital/ completion of home care treatment
6. Ambulance Cover	Coves expenses on Road ambulance subject to maximum of Rs 2000 per hospitalization.
Optional Covers	
7. Hospital Daily Cash	Covers 0.5% of Sum Insured per day subject to maximum of 15 days in a policy period for every insured member

Note: The total amount payable in respect of all the above-mentioned covers shall not exceed the 100% of Sum Insured

5. PROPOSER'S BANK DETAILS

Name of the Bank Account Holder	☐ Mr. ☐ Ms. ☐ Mrs. F I R S T M I D D L E L A S T				
Bank Name:					
Bank Account Number:		Account Type:	☐ Saving ☐ Current		
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 the bank)					
☐ I understand that 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.					


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6. DETAILS OF INSURED PERSON

Details	Member 1	Member 2	Member 3	Member 4	Member 5	Member 6	Member 7	Member 8
First Name								
Last Name								
Date of Birth								
Gender								
Relationship with Proposer	Self/ Spouse/ Son/ Daughter /Parents/ Parents in law	Self/ Spouse/ Son/ Daughter /Parents/ Parents in law	Self/ Spouse/ Son/ Daughter /Parents/ Parents in law	Self/ Spouse/ Son/ Daughter /Parents/ Parents in law	Self/ Spouse/ Son/ Daughter /Parents/ Parents in law	Self/ Spouse/ Son/ Daughter /Parents/ Parents in law	Self/ Spouse/ Son/ Daughter /Parents/ Parents in law	Self/ Spouse/ Son/ Daughter /Parents/ Parents in law
Occupation	☐ Healthcare Worker ☐ Others, pls specify ____	☐ Healthcare Worker ☐ Others, pls specify ____	☐ Healthcare Worker ☐ Others, pls specify ____	☐ Healthcare Worker ☐ Others, pls specify ____	☐ Healthcare Worker ☐ Others, pls specify ____	☐ Healthcare Worker ☐ Others, pls specify ____	☐ Healthcare Worker ☐ Others, pls specify ____	☐ Healthcare Worker ☐ Others, pls specify ____
Nationality								
Mobile No. and E-mail Id								

7. MEDICAL AND LIFESTYLES DETAILS OF THE PERSONS PROPOSED TO BE INSURED

Medical Details	Member 1	Member 2	Member 3	Member 4	Member 5	Member 6	Member 7	Member 8
Whether the Person proposed for Insurance or any of his/her family members with whom he/she is living, have ever been detected with COVID-19 or is Quarantined or recommended Quarantine:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Is any person proposed to be insured on (or prescribed to be on) regular medication?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No



Has any person proposed to be insured, undertaken (or been prescribed to undertake) any lab/ blood tests, imaging tests viz. scans/MRI in the last 4 years other than routine health check-up or pre-employment check-up?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Has any person proposed to be insured, undergone any surgery in the past 90 days?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Is any person proposed to be insured, planned to undergo any surgery at present or in the near future?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Is any person proposed to be insured suffering from (or suffered in the past) any other disease/illness/ accident/injury other than common cold or fever?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
If yes, was any person proposed to be insured diagnosed with any of these medical conditions with or without any follow-up tests/ medications? (Please tick as applicable)								
• Elevated Blood Sugar								
• Diabetes								
• Elevated Blood Pressure								
• Hypertension								
• High Cholesterol								
• Hypothyroidism								
Is any person proposed to be insured pregnant?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No



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IRDAI Registration No. 103 IndusInd General Insurance Company Limited (Formerly known as Reliance General Insurance). An ISO 9001:2015 Certified Company For complete details on the benefits, coverage, terms & conditions and exclusions, do read the sales brochure, prospectus and policy wordings carefully before concluding sale. Registered & Corporate Office: 6th Floor, Oberoi Commerz, International Business Park, Oberoi Garden City, Off. Western Express Highway, Goregaon (E), Mumbai-400063. Corporate Identity Number: U66603MH2000PLC128300. Corona Kavach Policy, IndusInd General. UIN No.: RELHLIP21092V012021. IGI/MCOM/CO/CKPIG/PF/Ver.1.0/120826.



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Has any application for life, health(or mediclaim), hospital daily cash or critical illness insurance for any person proposed to be insured ever been: (If you have mark any of the below options as yes, please give details under the next section)								
• Declined	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ 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	☐ 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	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

Lifestyle Details	Member 1	Member 2	Member 3	Member 4	Member 5	Member 6	Member 7	Member 8
Does any of the persons proposed to be insured use tobacco products/ cigarettes or drink alcohol?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ 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	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

8. PRE-EXISTING DETAILS

Details	Member 1	Member 2	Member 3	Member 4	Member 5	Member 6	Member 7	Member 8
Has the person proposed to be insured suffered from any of the following illnesses/sickness/medical conditions during the past 4 years? (Yes/No, Date of First Diagnosis):	☐ Yes ☐ No DD/MM/YYYY	☐ Yes ☐ No DD/MM/YYYY	☐ Yes ☐ No DD/MM/YYYY	☐ Yes ☐ No DD/MM/YYYY	☐ Yes ☐ No DD/MM/YYYY	☐ Yes ☐ No DD/MM/YYYY	☐ Yes ☐ No DD/MM/YYYY	☐ Yes ☐ No DD/MM/YYYY
Hypertension/ High blood pressure								
Diabetes/ High blood sugar/Sugar in urine								
Cancer, Tumour, Growth or Cyst of any kind								
Chest Pain/ Heart Attack or any other Heart Disease/ Problem								
Liver or Gall Bladder problems/Jaundice/ Hepatitis B or C								
Kidney Problems or Diseases of Reproductive organs								
Tuberculosis/ Asthma or any other Lung Disorder								
Ulcer (Stomach/ Duodenal), or any problems of Digestive System								
Any Blood Disorder (E.G. Anaemia, Haemophilia, Thalassemia)								
HIV Infection/Aids or Positive test for HIV								
Nervous, Psychiatric or Mental or sleep disorder								
Stroke/ Paralysis/ Epilepsy (Fits) or any other Nervous Disorder (Brain/ Spinal cord etc)								

Abnormal Thyroid Function/ Goitre or any Endocrine organ disorders							
Eye or vision disorders/ Ear/ Nose or Throat diseases							
Arthritis, Spondylosis, Fracture or any other disorder of Muscle Bone/ Joint/ Ligament/ Cartilage							
Any other disease/ condition not mentioned above							

Family Physician's details:

Name of Family Physician:	
Email ID:	
Contact Number:	

9. PREMIUM PAYMENT DETAILS

Payment by:	☐ Cheque ☐ DD ☐ Credit Card ☐ Debit Card ☐ NEFT ☐ Net Banking		
Cheque or DD amount in figures:	₹	Cheque/DD Date:	DD / MM / YYYY
Cheque or DD amount in words:	₹		
Cheque/DD/Card No:			
Bank Name:			
Name of Premium Payer:			

Note: In case the payment is made through Cheque/DD then please issue an a/c payee instrument in favour of "IndusInd General Insurance Company Limited"
 In case the payment is made through Credit/Debit Card the Card needs to be in the name of Proposer.

10. DECLARATION & WARRANTY BY THE APPLICANT

- 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/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 payment of the premium chargeable.
- 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.

- I declare and consent to the company seeking medical information from any doctor or hospital who 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 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.
- I 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.
- I consent to receive information from the Company through physical, electronic or telecommunication means from time to time
- I hereby state that the above-mentioned address shall be taken as address on record for the purpose of GST.
- 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.

Mandatory Declaration applicable only to Proposer who has opted occupation as Doctor/Health Care Worker

☐ I hereby confirm that I am a Doctor/ Health Care worker at "Name of the Institution"

Place: _____

Date: _____

Signature of Proposer

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) 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 state-owned 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: _____

Signature of Proposer

GENERAL DECLARATION:

I understand that as per the new AML/CFT Guidelines issued IndusInd General Insurance Co. Ltd will be verifying my details pertaining to KYC and PAN provided at the time of proposal.

I further, do hereby agree and consent that in the case of the event of a mismatch of information provided by me in the proposal form, identification proof, and address proof at the time of issuance of the policy. I request IndusInd General Insurance Company Limited to issue the policy with the details appearing as per my proposal form. I will be solely responsible for any consequences arising out of the difference in detail given by me during the verification of supporting documents provided by me at the time of issuance of the policy or otherwise.

ASSIGNMENT

I do hereby assign the monies payable by the IndusInd General Insurance Company Limited, in the event of my death to (Name and Relationship to the Insured) and I further declare that his/her /their receipt shall be sufficient discharge to the Company. Dated this day of 202 at

Signature of the Policy holder

WITNESS:

Name and Address

Signature

VERNACULAR DECLARATION

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

Place:

Date:

Signature/Thumb impression of Proposer

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

- No person shall allow or offer to allow, either directly or indirectly, as an inducement to any person to take out or renew or continue an insurance in respect of any kind of risk relating to lives or property in India, any rebate of the whole or part of the commission payable or any rebate of the premium shown on the policy, nor shall any person taking out or renewing or continuing a policy accept any rebate, except such rebate as may be allowed in accordance with the published prospectuses or tables of the insurer.
- Any person making default in complying with the provisions of this section shall be liable for a penalty which may extend to ten lakh rupees.



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ACKNOWLEDGEMENT FOR PROPOSAL

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

Date:

Proposal No.:

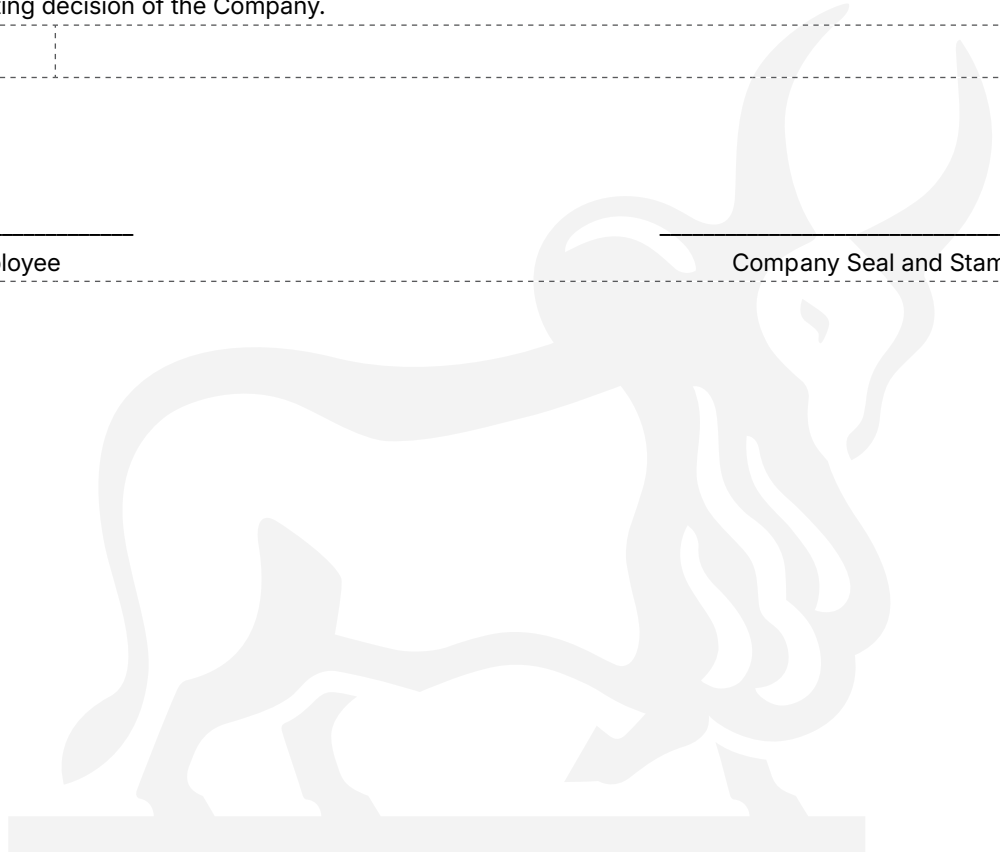
We acknowledge the receipt of payment of Rs _____ vide cheque/DD no. _____
from Mr./Mrs./Ms. _____

Please note that this is only an acknowledgement receipt and does not amount to acceptance of risk or commencement of Policy. IndusInd General Insurance Company Limited is 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



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