

Proposal Form No: _____

 Customer : ☐ New ☐ Existing

INDUSIND – YES PLUS HEALTH INSURANCE - PROPOSAL FORM

1. To be filled and signed by proposer
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 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.

A. INTERMEDIARY DETAILS (To be filled in BLOCK LETTERS)

Intermediary Name	Code
IMD Employee Name	Code
IMD Branch Name	Code

B. PROPOSER DETAILS (To be filled in BLOCK LETTERS)

1. Name of Proposer	☐ Mr. ☐ Ms. ☐ Mrs. F I R S T M I D D L E L A S T
2. Address	
	Pin Code*
Residence No.	Mobile*
Gender*	Marital Status (Married / Single / Others)*
Mother's Maiden Name*	
Nationality*	Date of Birth* DD/MM/YYYY (Mandatory)
UID Aadhaar No.	Email ID*
Yes Bank Customer ID*	PAN No.:
Pan No.:	(Mandatory) If not Provided Form 60 Required
3. Do you have a GST Registration Number	☐ Yes ☐ No
If Yes, please specify	
Source of Funds	☐ Business ☐ Profession ☐ Salary ☐ Agricultural Income ☐ Savings ☐ Others
Occupations	☐ Salaried ☐ Self Employed ☐ Other
Monthly Income	☐ Upto ₹ 20,000 ☐ ₹ 20,001 to ₹ 50,000 ☐ ₹ 50,001 to ₹ 1,00,000 ☐ ₹ 1,00,001 and above
Yes Bank Account*	☐ Saving ☐ Current ☐ Credit Card ☐ Loan Ac
Do you have ABHA ID or ABHA address	☐ Yes ☐ No
If yes, please specify the details	

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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. IndusInd – Yes Plus Health Insurance. UIN No.: RELHGP21006V012021. IGI/MCOM/CO/HL-06/IYPHI/PF/Ver. 1.2/160326.


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CKYC ID (for Individual Customer)	
CIN No. (for Corporate customer)	

C. PROPOSER'S BANK DETAILS

1. Name of the Bank Account Holder	☐ Mr. ☐ Ms. ☐ Mrs.	F I R S T	M I D D L E	L A S T
2. Bank Account No.:		3. Account:	☐ Saving ☐ Current	
4. Name of the Bank				
5. Branch				
6. MICR Code (9 digit MICR code number of the bank and branch appearing on the cheque issued by the bank)				
7. IFSC Code (11 character code appearing on your cheque leaf)				
☐ 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.				

D. 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/hers

Name of Nominee	Date of Birth	Relationship with Proposer	Address of Nominee
	DD/MM/YYYY		
	DD/MM/YYYY		

If the Nominee is minor, name and address of Appointee and Relationship with Minor:

Name	Mobile No.	Email	Aadhaar Number / Virtual ID	Date of Birth	Relationship

E. Please tick the per-existing disease as per insured

Lifestyle / Disease questionnaire		Member 1		Member 2		Member 3		Member 4	
Sr. No.	Have you ever suffered from any of the following illness / sickness or medical conditions during the last 4 year? (You requested to disclose these information in a truthful manner. Any wrong information can lead to hassles at the time of claims, if any)	Do you suffer from?	First Diagnosis Date	Do you suffer from?	First Diagnosis Date	Do you suffer from?	First Diagnosis Date	Do you suffer from?	First Diagnosis Date
1.	Diabetes, Impaired Glucose Tolerance (Pre - Diabetes), Thyroid / Pituitary disorder?	☐ Yes ☐ No	dd/mm/yy	☐ Yes ☐ No	dd/mm/yy	☐ Yes ☐ No	dd/mm/yy	☐ Yes ☐ No	dd/mm/yy

2.	High Blood Pressure / Hypertension, Low Blood Pressure, Chest Pain, any ailment/ diseases of the Heart?	☐ Yes ☐ No	dd/mm/yy	☐ Yes ☐ No	dd/mm/yy	☐ Yes ☐ No	dd/mm/yy	☐ Yes ☐ No	dd/mm/yy
3.	Undertaken any surgery or a surgery been advised and have surgery still pending?	☐ Yes ☐ No	dd/mm/yy	☐ Yes ☐ No	dd/mm/yy	☐ Yes ☐ No	dd/mm/yy	☐ Yes ☐ No	dd/mm/yy
4.	Asthma, Bronchitis, Tuberculosis, Breathing difficulties or disorder of the lung/ respiratory track?	☐ Yes ☐ No	dd/mm/yy	☐ Yes ☐ No	dd/mm/yy	☐ Yes ☐ No	dd/mm/yy	☐ Yes ☐ No	dd/mm/yy
5.	HIV/AIDs, any sexually transmitted diseases or any ailment of the immune system?	☐ Yes ☐ No	dd/mm/yy	☐ Yes ☐ No	dd/mm/yy	☐ Yes ☐ No	dd/mm/yy	☐ Yes ☐ No	dd/mm/yy
6.	Jaundice, Liver Cirrhosis, Fatty Liver Disease, Gall Bladder Stone, Pancreatic Disease, Hepatitis B or any other disorder of the liver or pancreas?	☐ Yes ☐ No	dd/mm/yy	☐ Yes ☐ No	dd/mm/yy	☐ Yes ☐ No	dd/mm/yy	☐ Yes ☐ No	dd/mm/yy
7.	Ulcer of the stomach / duodenal, piles/anal fistula, Inflammatory Bowel Diseases or any other ailment of the digestive system?	☐ Yes ☐ No	dd/mm/yy	☐ Yes ☐ No	dd/mm/yy	☐ Yes ☐ No	dd/mm/yy	☐ Yes ☐ No	dd/mm/yy
8.	Tumour - benign or malignant or any growth, cyst, mass anywhere in the body?	☐ Yes ☐ No	dd/mm/yy	☐ Yes ☐ No	dd/mm/yy	☐ Yes ☐ No	dd/mm/yy	☐ Yes ☐ No	dd/mm/yy
9.	Arthritis, Spondylosis of any other disorder of bone, muscles or joints, Avascular Necrosis?	☐ Yes ☐ No	dd/mm/yy	☐ Yes ☐ No	dd/mm/yy	☐ Yes ☐ No	dd/mm/yy	☐ Yes ☐ No	dd/mm/yy
10.	Kidney Failure, Stone in kidney and urinary tract, Prostate disorder or any other kidney/ urinary tract disorder? Any time you have undergone a dialysis?	☐ Yes ☐ No	dd/mm/yy	☐ Yes ☐ No	dd/mm/yy	☐ Yes ☐ No	dd/mm/yy	☐ Yes ☐ No	dd/mm/yy
11.	Stroke, Epilepsy (fits), Paralysis or other nervous system (Brain, spinal cord, etc) disorder?	☐ Yes ☐ No	dd/mm/yy	☐ Yes ☐ No	dd/mm/yy	☐ Yes ☐ No	dd/mm/yy	☐ Yes ☐ No	dd/mm/yy
12.	Diseases of the Ear/Nose/Throat/Teeth/ Eye (please mention Dioptres in case of refractory error)?	☐ Yes ☐ No	dd/mm/yy	☐ Yes ☐ No	dd/mm/yy	☐ Yes ☐ No	dd/mm/yy	☐ Yes ☐ No	dd/mm/yy
13.	Anemia, Leukaemia, Lymphoma or any other blood/Lymphatic system disease or Sarcoidosis, Papulosquamous disorder of skin?	☐ Yes ☐ No	dd/mm/yy	☐ Yes ☐ No	dd/mm/yy	☐ Yes ☐ No	dd/mm/yy	☐ Yes ☐ No	dd/mm/yy
14.	Psychiatric/Mental illnesses or sleep disorder, Alzheimers Disease, Parkinsons Disease?	☐ Yes ☐ No	dd/mm/yy	☐ Yes ☐ No	dd/mm/yy	☐ Yes ☐ No	dd/mm/yy	☐ Yes ☐ No	dd/mm/yy
15.	Any disability or sickness from birth / early childhood?	☐ Yes ☐ No	dd/mm/yy	☐ Yes ☐ No	dd/mm/yy	☐ Yes ☐ No	dd/mm/yy	☐ Yes ☐ No	dd/mm/yy
16.	Uterine Fibroid, Fibroadenoma breast or any other Gynaecological (Female reproductive system)/breast disorder?	☐ Yes ☐ No	dd/mm/yy	☐ Yes ☐ No	dd/mm/yy	☐ Yes ☐ No	dd/mm/yy	☐ Yes ☐ No	dd/mm/yy
17.	Been addicted to alcohol, narcotics, and habit forming drugs or been under detoxication therapy?	☐ Yes ☐ No	dd/mm/yy	☐ Yes ☐ No	dd/mm/yy	☐ Yes ☐ No	dd/mm/yy	☐ Yes ☐ No	dd/mm/yy
18.	Been under any regular medication (self/ prescribed)?	☐ Yes ☐ No	dd/mm/yy	☐ Yes ☐ No	dd/mm/yy	☐ Yes ☐ No	dd/mm/yy	☐ Yes ☐ No	dd/mm/yy
19.	Undertaken any lab/blood tests, imaging tests viz. scans/MRI in the last 5 years other than routine health check-up or pre-employment check-up?	☐ Yes ☐ No	dd/mm/yy	☐ Yes ☐ No	dd/mm/yy	☐ Yes ☐ No	dd/mm/yy	☐ Yes ☐ No	dd/mm/yy
20.	Is any of the insured pregnant? If yes please mention the expected date of delivery. Any complication during current or earlier pregnancy?	☐ Yes ☐ No	dd/mm/yy	☐ Yes ☐ No	dd/mm/yy	☐ Yes ☐ No	dd/mm/yy	☐ Yes ☐ No	dd/mm/yy
21.	Has an ailment or disability or deformity	☐ Yes ☐ No	dd/mm/yy	☐ Yes ☐ No	dd/mm/yy	☐ Yes ☐ No	dd/mm/yy	☐ Yes ☐ No	dd/mm/yy


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22.	Other Please specify	☐ Yes ☐ No	dd/mm/yy	☐ Yes ☐ No	dd/mm/yy	☐ Yes ☐ No	dd/mm/yy	☐ Yes ☐ No	dd/mm/yy
23.	If you have ticked 'Yes' in any of the boxes above, please name the disease/condition here.	☐ Yes ☐ No	dd/mm/yy	☐ Yes ☐ No	dd/mm/yy	☐ Yes ☐ No	dd/mm/yy	☐ Yes ☐ No	dd/mm/yy

E1. Please tick the per-existing disease as per insured

Lifestyle / Disease questionnaire		Member 5		Member 6		Member 7		Member 8	
Sr. No.	Have you ever suffered from any of the following illness / sickness or medical conditions during the last 4 year? (You requested to disclose these information in a truthful manner. Any wrong information can lead to hassles at the time of claims, if any)	Do you suffer from?	First Diagnosis Date	Do you suffer from?	First Diagnosis Date	Do you suffer from?	First Diagnosis Date	Do you suffer from?	First Diagnosis Date
1.	Diabetes, Impaired Glucose Tolerance (Pre - Diabetes), Thyroid / Pituitary disorder?	☐ Yes ☐ No	dd/mm/yy	☐ Yes ☐ No	dd/mm/yy	☐ Yes ☐ No	dd/mm/yy	☐ Yes ☐ No	dd/mm/yy
2.	High Blood Pressure / Hypertension, Low Blood Pressure, Chest Pain, any ailment/ diseases of the Heart?	☐ Yes ☐ No	dd/mm/yy	☐ Yes ☐ No	dd/mm/yy	☐ Yes ☐ No	dd/mm/yy	☐ Yes ☐ No	dd/mm/yy
3.	Undertaken any surgery or a surgery been advised and have surgery still pending?	☐ Yes ☐ No	dd/mm/yy	☐ Yes ☐ No	dd/mm/yy	☐ Yes ☐ No	dd/mm/yy	☐ Yes ☐ No	dd/mm/yy
4.	Asthma, Bronchitis, Tuberculosis, Breathing difficulties or disorder of the lung/ respiratory track?	☐ Yes ☐ No	dd/mm/yy	☐ Yes ☐ No	dd/mm/yy	☐ Yes ☐ No	dd/mm/yy	☐ Yes ☐ No	dd/mm/yy
5.	HIV/AIDs, any sexually transmitted diseases or any ailment of the immune system?	☐ Yes ☐ No	dd/mm/yy	☐ Yes ☐ No	dd/mm/yy	☐ Yes ☐ No	dd/mm/yy	☐ Yes ☐ No	dd/mm/yy
6.	Jaundice, Liver Cirrhosis, Fatty Liver Disease, Gall Bladder Stone, Pancreatic Disease, Hepatitis B or any other disorder of the liver or pancreas?	☐ Yes ☐ No	dd/mm/yy	☐ Yes ☐ No	dd/mm/yy	☐ Yes ☐ No	dd/mm/yy	☐ Yes ☐ No	dd/mm/yy
7.	Ulcer of the stomach / duodenal, piles/anal fistula, Inflammatory Bowel Diseases or any other ailment of the digestive system?	☐ Yes ☐ No	dd/mm/yy	☐ Yes ☐ No	dd/mm/yy	☐ Yes ☐ No	dd/mm/yy	☐ Yes ☐ No	dd/mm/yy
8.	Tumour - benign or malignant or any growth, cyst, mass anywhere in the body?	☐ Yes ☐ No	dd/mm/yy	☐ Yes ☐ No	dd/mm/yy	☐ Yes ☐ No	dd/mm/yy	☐ Yes ☐ No	dd/mm/yy
9.	Arthritis, Spondylosis of any other disorder of bone, muscles or joints, Avascular Necrosis?	☐ Yes ☐ No	dd/mm/yy	☐ Yes ☐ No	dd/mm/yy	☐ Yes ☐ No	dd/mm/yy	☐ Yes ☐ No	dd/mm/yy
10.	Kidney Failure, Stone in kidney and urinary tract, Prostate disorder or any other kidney/ urinary tract disorder? Any time you have undergone a dialysis?	☐ Yes ☐ No	dd/mm/yy	☐ Yes ☐ No	dd/mm/yy	☐ Yes ☐ No	dd/mm/yy	☐ Yes ☐ No	dd/mm/yy
11.	Stroke, Epilepsy (fits), Paralysis or other nervous system (Brain, spinal cord, etc) disorder?	☐ Yes ☐ No	dd/mm/yy	☐ Yes ☐ No	dd/mm/yy	☐ Yes ☐ No	dd/mm/yy	☐ Yes ☐ No	dd/mm/yy
12.	Diseases of the Ear/Nose/Throat/Teeth/ Eye (please mention Dioptres in case of refractory error)?	☐ Yes ☐ No	dd/mm/yy	☐ Yes ☐ No	dd/mm/yy	☐ Yes ☐ No	dd/mm/yy	☐ Yes ☐ No	dd/mm/yy
13.	Anemia, Leukaemia, Lymphoma or any other blood/Lymphatic system disease or Sarcoidosis, Papulosquamous disorder of skin?	☐ Yes ☐ No	dd/mm/yy	☐ Yes ☐ No	dd/mm/yy	☐ Yes ☐ No	dd/mm/yy	☐ Yes ☐ No	dd/mm/yy
14.	Psychiatric/Mental illnesses or sleep disorder, Alzheimers Disease, Parkinsons Disease?	☐ Yes ☐ No	dd/mm/yy	☐ Yes ☐ No	dd/mm/yy	☐ Yes ☐ No	dd/mm/yy	☐ Yes ☐ No	dd/mm/yy
15.	Any disability or sickness from birth / early childhood?	☐ Yes ☐ No	dd/mm/yy	☐ Yes ☐ No	dd/mm/yy	☐ Yes ☐ No	dd/mm/yy	☐ Yes ☐ No	dd/mm/yy


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16.	Uterine Fibroid, Fibroadenoma breast or any other Gynaecological (Female reproductive system)/breast disorder?	☐ Yes ☐ No	dd/mm/yy	☐ Yes ☐ No	dd/mm/yy	☐ Yes ☐ No	dd/mm/yy	☐ Yes ☐ No	dd/mm/yy
17.	Been addicted to alcohol, narcotics, and habit forming drugs or been under detoxication therapy?	☐ Yes ☐ No	dd/mm/yy	☐ Yes ☐ No	dd/mm/yy	☐ Yes ☐ No	dd/mm/yy	☐ Yes ☐ No	dd/mm/yy
18.	Been under any regular medication (self/prescribed)?	☐ Yes ☐ No	dd/mm/yy	☐ Yes ☐ No	dd/mm/yy	☐ Yes ☐ No	dd/mm/yy	☐ Yes ☐ No	dd/mm/yy
19.	Undertaken any lab/blood tests, imaging tests viz. scans/MRI in the last 5 years other than routine health check-up or pre-employment check-up?	☐ Yes ☐ No	dd/mm/yy	☐ Yes ☐ No	dd/mm/yy	☐ Yes ☐ No	dd/mm/yy	☐ Yes ☐ No	dd/mm/yy
20.	Is any of the insured pregnant? If yes please mention the expected date of delivery. Any complication during current or earlier pregnancy?	☐ Yes ☐ No	dd/mm/yy	☐ Yes ☐ No	dd/mm/yy	☐ Yes ☐ No	dd/mm/yy	☐ Yes ☐ No	dd/mm/yy
21.	Has an ailment or disability or deformity	☐ Yes ☐ No	dd/mm/yy	☐ Yes ☐ No	dd/mm/yy	☐ Yes ☐ No	dd/mm/yy	☐ Yes ☐ No	dd/mm/yy
22.	Other Please specify	☐ Yes ☐ No	dd/mm/yy	☐ Yes ☐ No	dd/mm/yy	☐ Yes ☐ No	dd/mm/yy	☐ Yes ☐ No	dd/mm/yy
23.	If you have ticked 'Yes' in any of the boxes above, please name the disease/condition here.	☐ Yes ☐ No	dd/mm/yy	☐ Yes ☐ No	dd/mm/yy	☐ Yes ☐ No	dd/mm/yy	☐ Yes ☐ No	dd/mm/yy

Has any of the persons proposed to be insured

Sr. No	Questions	Yes / No
1.	Been addicted to alcohol, narcotics, and habit forming drugs or been under detoxication therapy?	
2.	Been under any regular medication (Self / Prescribed)?	
3.	Undertaken any lab/blood tests, imaging tests viz. scans/MRI other than routine health check-up or pre employment check-up?	
4.	Undertaken any surgery or a surgery been advised and have surgery still pending?	
5.	Does any person proposed to be insured smoke or consume gutkha / Pan masala or alcohol If yes please provide the details and quantity per week	☐ Yes ☐ No

F. Family Physician's Details

Name of Family Physician:	☐ Mr. ☐ Ms. ☐ Mrs.		
Contact Number		Email Id	

G. Details of person(s) proposed to be insured

Details		Member 1	Member 2	Member 3	Member 4	Member 5	Member 6	Member 7	Member 8
Name	First Name								
	Last Name								
DOB		DD/MM/YY	DD/MM/YY	DD/MM/YY	DD/MM/YY	DD/MM/YY	DD/MM/YY	DD/MM/YY	DD/MM/YY
Gender									

Nationality								
Relationship with Proposer								

*Applicable in case of Family Plan

*For additional member details, kindly use supplement sheet attached to this document.

Vaccination & COVID-19 Medical Questions						
Vaccination Details	Member 1	Member 2	Member 3	Member 4	Member 5	Member 6
ID Proof Verified/Submitted for vaccination registration						
Beneficiary Reference ID						
Date of Dose & Batch No						
Have you and/or any of your immediate family members travelled outside India in the last 45 days or do you plan to travel outside India during the next 6 months?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Have you and/or any of your immediate family members tested positive for COVID-19 or are awaiting results of such a test or been advised to be under quarantine due to COVID-19?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Are you and/or any of your immediate family members currently suffering from or in the last 2 months, have suffered from fever, persistent cough, sore throat, breathing difficulties, gastrointestinal symptoms (vomiting/diarrhea)?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

H. Plan / Policy Details						
(Please select Sum Insured option and Deductible options, Type of policy and Policy Period of your choice from plans below)						
Policy Period: 1 year		Proposed Policy Start Date DD/MM/YY				
Aggregate Deductible (in Lakhs)	Sum Insured (in Lakhs)					
2 Lakhs	3 Lakhs ☐	5 Lakhs ☐	8 Lakhs ☐			
3 Lakhs	7 Lakhs ☐	12 Lakhs ☐				
5 Lakhs	5 Lakhs ☐	10 Lakhs ☐	15 Lakhs ☐	20 Lakhs ☐		
7 Lakhs	8 Lakhs ☐	13 Lakhs ☐	18 Lakhs ☐	23 Lakhs ☐	28 Lakhs ☐	
10 Lakhs	10 Lakhs ☐	15 Lakhs ☐	20 Lakhs ☐	25 Lakhs ☐	30 Lakhs ☐	40 Lakhs ☐
Please refer policy wordings and prospectus for details of plan						

I. Existing Health Insurance Policy Details, If any

Member	Insurer Name	Policy Number	Start date	End date	Sum Insured	CB (% or Amount)	Claim under the policy in past 3 years
Member 1						Y/N	Y/N
Member 2						Y/N	Y/N
Member 3						Y/N	Y/N
Member 4						Y/N	Y/N
Member 5						Y/N	Y/N
Member 6						Y/N	Y/N
Member 7						Y/N	Y/N
Member 8						Y/N	Y/N

J. Premium Payment Details

Payment by: Cheque*/DD* / Credit Card#/Debit Card # ☐ Cheque ☐ DD ☐ Credit Card ☐ Debit Card
 (Tick whichever is applicable)

Cheque or DD Amount /-

Amount in words

Bank Name

Cheque No./DD No./Card No. Cheque/DD Date DD / MM / YYYY

Name of the Premium Payer

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

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

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

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

- i. I hereby declare on my behalf & on behalf of all persons proposed to be insured that the above statements, answers and/or particulars given by me in this proposal form are true and complete in all respects to the best of my knowledge and that I/We am/are authorized to propose on behalf of these other persons.
- ii. I understand that the information provided by me will form the basis of 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.
- iii. I/We further declare that I/We will notify in writing any change occurring in the occupation or general health of the life to be insured / proposer after the proposal has been submitted but before communication of the risk acceptance by the Company.
- iv. I/We declare and consent to the Company seeking medical information from any Doctor or from a hospital who at anytime 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 settlement.
- v. I/We authorize the company to share information pertaining to my proposal including the medical records for the sole purpose of proposal underwriting and/or claims settlement and with any Governmental and / or Regulatory Authority.
- vi. I/We consent to receive information from the Company through physical, electronic or telecommunication means from time to time.
- vii. I/We here by state that the above mentioned address shall be taken as address on record for the purpose of GST.
- viii. 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

Place: _____

Date: _____

Signature of Proposer & Seal of Company

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)

Explained By
Intermediary (Name):

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

Date: DD/MM/YYYY

Place: _____

Place: _____

Date: _____

Signature of Intermediary

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.

Note - 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 **services@indusindinsurance.com**

K. Acknowledgement for Proposal

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

NOT VALID AGAINST CASH

Proposal Form No. _____

Date: DD / MM / YYYY

We acknowledge the receipt of payment of ₹ _____ 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 General 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: _____

Signature of the Employee: _____ Company Seal & Stamp _____



indusindinsurance.com

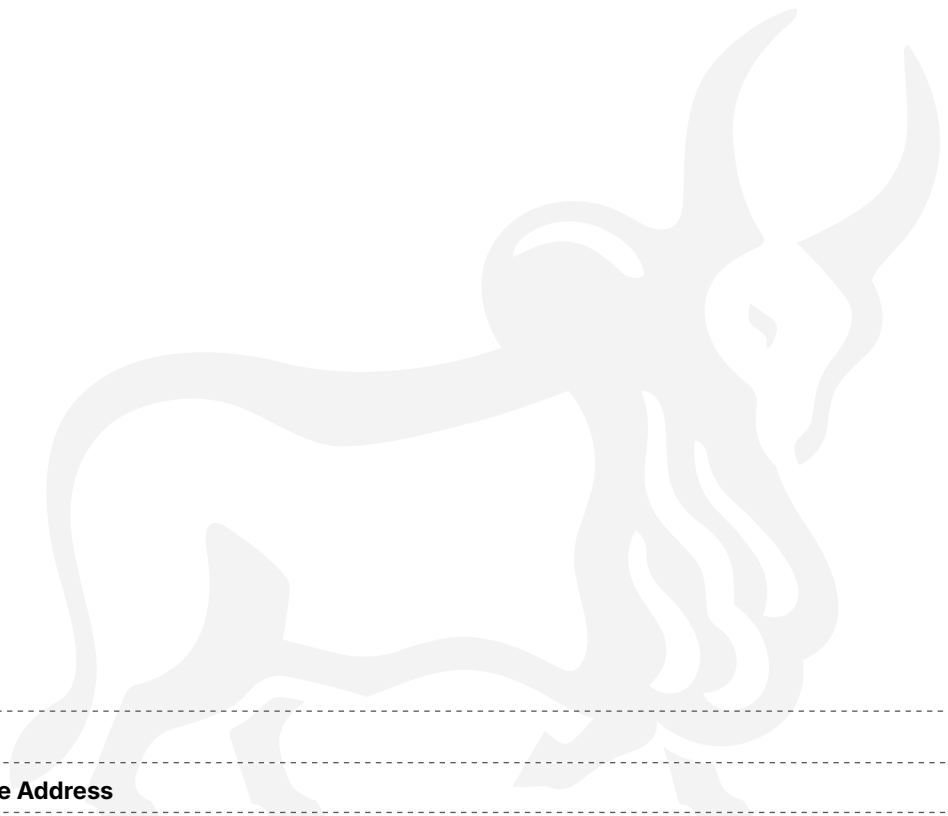


022 4890 3009 (Paid)



74004 22200 (WhatsApp)





Registered & Corporate Office Address

IRDAI Registration No. 103. IndusInd General Insurance Company Limited.

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. IndusInd Critical Illness Policy UIN:RELHLGP08003V010708

