

Proposal Form No: _____

INDUSIND HEALTHWISE POLICY - PROPOSAL FORM
Please note:

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 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

ABOUT INTERMEDIARY

Intermediary Name		Intermediary Code	
Branch Name		Branch Code	
Sales Manager Name		Sales Manager Code	

ABOUT YOU (PROPOSER)

Name of the Proposer	☐ Mr. ☐ Ms. ☐ Mrs. F I R S T M I D D L E L A S T		
Address			
Flat / Building:		Road/Street/Sector	
Area		City	
Pin Code		State	
Zone*			

I hereby declare on my behalf & on behalf of all persons proposed to be insured that I will pay premium as per Zone A/Zone B (Strike whichever is not applicable)

*Geographical Rating structure is being introduced i.e. Zone A – (Maharashtra, Gujarat, Delhi, Haryana, Uttar Pradesh & Bangalore) and Zone B (Rest of India). In order to avoid any hassle in case of claims being administered from a zone different from the policy pricing zone (zone A/zone B) geographical Co-pay is introduced. Below is the illustration of co-pay applicability:

PRICING/ PREMIUM PAYING ZONE	CLAIMS ZONE	CO - PAY (YES/NO)
Zone A	Zone A	No Co-pay
Zone B	Zone B	No Co-pay
Zone A	Zone B	No Co-pay
Zone B	Zone A	Co-pay of 25%

PROPOSER OF A DIFFERENT ZONE CAN OPT A DIFFERENT ZONE FOR PREMIUM PAYMENT

Country		Residence Number	
Mobile		Gender	☐ Male ☐ Female
Marital Status	☐ Married ☐ Single ☐ Other	Date of Birth	DD / MM / YYYY
Mother's Maiden Name			


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022 4890 3009 (Paid)



74004 22200 (WhatsApp)

IndusInd
 Insurance App


Download Now



PAN No. (Mandatory) If not provided Form 60 required.		UID Aadhaar No.	
Email Id	Nationality		DD / MM / YYYY
CKYC No.	(for Individual customer)		
Do you have a GST Registration Number		☐ ☐	
If Yes, please specify			
Source of Funds	☐ Business ☐ Profession ☐ Salary ☐ Agricultural Income ☐ Savings ☐ Other		
Monthly Income	☐ Upto ₹20000 ☐ ₹20001 to ₹50000 ☐ ₹50001 to ₹ 100000 ☐ ₹100000 & above		
Source of Funds	☐ Business ☐ Profession ☐ Salary ☐ Agricultural Income ☐ Savings ☐ Other		

YOUR (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:			
MICR Code (9 digit MICR code number of the bank and branch appearing on the cheque issued by the bank)			
IFSC Code (11 character code appearing on your cheque leaf)			
☐ 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.			

PLAN/POLICY DETAILS

Plan	☐ Standard ☐ Silver ☐ Gold	Sum Insured
Cover Type	☐ ☐ Floater	Policy Tenure
No. of members to be covered	_____ (1-4 members) (Minimum 2 Members in case of Floater)	

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.

Benefit	Standard Plan	Silver Plan	Gold Plan
Base Cover			
In-patient Hospitalisation	Covers In-patient Hospitalisation expenses up to the Sum Insured.		
Domiciliary Hospitalisation	Limited to 10% of Sum Insured, for medical expenses incurred for availing Medical treatment at home which would have otherwise required hospitalisation		
Day care treatment	Covered as listed in Annexure D		
Pre-Hospitalisation Medical Expenses	30 days 60 days	60 days	60 days
Post-Hospitalisation Medical Expenses	60 days 90 days	90 days	90 days

Pre-Existing Disease coverage	5th Policy Year onward	3rd Policy Year onward	3rd Policy Year onward
Critical Illness	Not covered	Not covered	Covered for an additional amount equivalent to the Sum Insured
Donor Expenses	Not covered	Covered within the Sum Insured limit	Covered within the Sum Insured limit
Cost of Health Check-up	Reimbursement of cost of medical check-up upto 1% of average Sum Insured for individual policies and upto 1.25% for Floater covers, once at the end of a block of four consecutive years provided there are no claims reported under the policies by any member, during the block.		
Modern Treatment	Covered upto 50% of Sum Insured		
Base Cover			
Daily Hospitalisation Allowance	Not covered	Not covered	Rs. 250 per day, upto 7 days, starting from day 4 to day 10. In case of listed Critical Illness, said allowance will be payable upto 14 days.
Nursing Allowance (Per day amount)	Not covered	Rs.250 per day for period of maximum of 5 days	Rs.300 per day for a for a maximum period of 5 days. In case of listed Critical Illness, the said extended to maximum of 10 days
Local Road Ambulance Service	Upto Rs. 500/-	Upto Rs. 750/-	Upto Rs. 1000/-
Recovery Benefit	Not covered	Covered -If in case an insured person is hospitalized for more than 10 days, a lump-sum of Rs. 10,000/- will be paid.	
Expenses on accompanying person(per day amount)	Rs. 200/- per day for a maximum period of 5 days subject to Insured Person is hospitalized for a period of 5 days at a given time	Rs. 250/- per day for a maximum period of 5 days subject to Insured Person is hospitalized for a period of 5 days at a given time	Rs. 300/- per day for a maximum period of 5 days subject to Insured Person is hospitalized for a period of 5 days at a given time

YOUR NOMINEE DETAILS

The nominee as declared hereunder shall become eligible for claim payment under the Policy as per the terms and conditions of the Policy, in the event of the death of the Policyholder. The receipt of proceeds by the nominee would be sufficient discharge to the Company. Nominee for all other person(s) proposed shall be the proposer himself/herself.

Name of the Nominee

Date of Birth

DD / MM / YYYY

Relationship with Proposer

Address of Nominee

7. DETAILS OF INSURED PERSON

SECTION A: PERSONAL DETAILS

Details	Member 1	Member 2	Member 3	Member 4
Name of the Insured Person				
First Name				
Last Name				
Gender	(M / F / Others)	(M / F / Others)	(M / F / Others)	(M / F / Others)
Date of Birth	DD / MM / YYYY	DD / MM / YYYY	DD / MM / YYYY	DD / MM / YYYY



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022 4890 3009 (Paid)



74004 22200 (WhatsApp)



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
Nationality				
Marital Status				
Occupation				
Height (in cms.)				
Weight (in Kgs.)				
Has any person to be insured been diagnosed/hospitalized/under any treatment for any illness / disease or injury during any time in past? If yes please select the disease / injury as mentioned below. If others, please specify				
A. Diabetes				
B. Hypertension				
C. Respiratory disorder(s)				
D. HIV/AIDS/STD				
E. Liver disease(s)				
F. Cancer/Tumor				
G. Heart Disease(s)				
H. Arthritis/Joint pain				
I. Kidney Disease(s)				
J. Paralysis/Stroke				
K. Congenital Disease(s)				
L. Injury				
M. Others (Please Specify)				
Name of Disease / Injury				
Since				
Does any person proposed to be insured smoke or consume tobacco or alcohol? If yes, please indicate	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
SECTION B: CURRENT/PREVIOUS HEALTH - INSURANCE DETAILS				
Details	Member 1	Member 2	Member 3	Member 4
Name of the Insurer				
Policy no.				
Policy period				
From (DD/MM/YYYY)				
To (DD/MM/YYYY)				
Sum Insured (₹)				
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 illness 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? (Including Critical Illness)	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Are you applying for portability?	☐ Yes ☐ No (If yes, please fill in the separate Portability Form)			
M. Others (Please Specify)				

ATTENDING PHYSICIAN'S DETAILS

Name of Family Physician			
Contact Number		Email Id	

PREMIUM PAYMENT DETAILS

Payment by:	(Tick whichever is applicable) ☐ Cheque ☐ DD ☐ Credit Card ☐ Debit Card ☐ NEFT ☐ Net Banking		
Cheque or DD amount in figures:	₹		
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

E- ACCOUNT OPENING

IndusInd General Insurance recommends to move towards a smarter and faster way of transacting by opening an e-Insurance account. Check here to opt in for E-Insurance account. (Please click on the link sent to you on your registered mobile no through SMS and complete the e-IA Registration form)

DECLARATION & WARRANTY BY THE APPLICANT

- i. I have read and understood the brochure, prospectus, sales literature & Policy wordings and confirm to abide by the same.
- ii. 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
- iii. I understand that the information provided by me will form the basis of the insurance policy, is subject to the Board approved underwriting policy of the insurance company and that the policy will come into force only after full receipt of the premium chargeable
I 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 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.
- iv. 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.
- v. Receipt of the Proposal form by the Company shall not be construed as acceptance of proposal. I hereby agree that the insurance coverage shall commence Only on realization of full premium and on receipt of complete medical reports (wherever applicable) and subject to individual underwriting by the Company. The Company at its sole discretion reserves the right to accept or reject or load any proposal without assigning any reason thereof.
- vi. I understand that the Policy shall become void at the Company's option, in the event of any untrue or incorrect statement, misrepresentation, misdescription 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.
- vii. 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.
- viii. 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.
- ix. I consent to receive information from the Company through physical, electronic or telecommunication means from time to time.
- x. 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.

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) 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

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

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: _____

Time: _____

Identified by Name & Signature

Signature/Thumb impression of Proposer

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

ACKNOWLEDGEMENT FOR PROPOSAL

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

Proposal Form no.	Date
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