

PROPOSAL FORM

Arogya Sanjeevani Policy, Raheja QBE General Insurance Company Limited - Proposal Form (URN-RQBESA2021-08)

Photograph
of Proposer

IMPORTANT GUIDELINES:

1. The liability of the Company does not commence until the acceptance of the proposal has been formally intimated to the insured and full premium has been realized by the Company.
2. All details are mandatory.

(Please fill-up this form in CAPITAL LETTERS)

INSURED PERSONS DETAILS & SUM INSURED

Last Name										First Name										Middle Name																			
Proposer (Mr/ Mrs / Ms) :																																							
Address :																																							
City/Town :																																							
District :										State :																													
Telephone :										pin Code :										Mobile :																			
E-mail :																																							
Date of Birth :										Gender : M F					Marital Status: Married / unmarried																								
Nationality (Indian/Foreign) :										Country Name (if foreign national) :																													
Profession: Salaried										Self Employed										Others										PAN No.*									

(Please provide Form 60 if PAN Card is not available)

ABHA ID:

If any of the proposed applicant /insured is Politically exposed person (PEP) or close relative of PEP:

Details if PEP yes:

ADDITIONAL KYC DETAILS*

CKYC number (Mandatory for KYC update request)		
Identity Proof: (tick any one) <ul style="list-style-type: none"> <input type="checkbox"/> A - Passport number <input type="checkbox"/> B - Aadhar card <input type="checkbox"/> C - PAN card <input type="checkbox"/> D - Driving License <input type="checkbox"/> E - Voter ID card <input type="checkbox"/> Z - Others (any document notified by the central government) 	<input type="checkbox"/> A - Passport number <input type="checkbox"/> B - Aadhar card <input type="checkbox"/> C - PAN card <input type="checkbox"/> D - Driving License <input type="checkbox"/> E - Voter ID card <input type="checkbox"/> Z - Others (any document notified by the central government)	Please enter document number in about field.
Proof of address: (tick any one) <ul style="list-style-type: none"> <input type="checkbox"/> Passport <input type="checkbox"/> Driving license <input type="checkbox"/> Voter ID card <input type="checkbox"/> Electricity or Telephone Bill <input type="checkbox"/> Others 	<input type="checkbox"/> Passport <input type="checkbox"/> Driving license <input type="checkbox"/> Voter ID card <input type="checkbox"/> Electricity or Telephone Bill <input type="checkbox"/> Others	please specify document name and details if Others: <input type="text"/>

e-Insurance Account (eIA)*

Would you like to opt for Electronic Policy Issuance through an e-Insurance Account (eIA) of an Insurance Repository?*	<input type="checkbox"/> Yes <input type="checkbox"/> No
If you already have an eIA, provide details: a) Name of Insurance Repository b) eIA account No: c) Name as appearing in eIA	<input type="text"/> <input type="text"/> <input type="text"/>
If you do not have an eIA, would you like to open an account?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, choose any one Insurance Repository:	<input type="checkbox"/> CAMS Repository Services Limited <input type="checkbox"/> NSDL Data Management Limited <input type="checkbox"/> Karvy Insurance Repository Limited <input type="checkbox"/> Central Insurance Repository Limited

PROPOSAL FORM

PLAN DETAILS

Type of cover: Individual / Floater

Sun Insured : _____ Proposed Policy Period : From To

DETAILS OF THE PERSON PROPOSED TO BE INSURED

Sr No	Name of the Insured Person	Height (cms)	Weight (kg)	Relationship to Proposer	Gender CM/F/TG)	Date of Birth	ABHA ID No.
1						DD/MM/YYYY	
2						DD/MM/YYYY	
3						DD/MM/YYYY	
4						DD/MM/YYYY	
5						DD/MM/YYYY	
6						DD/MM/YYYY	
7						DD/MM/YYYY	
8						DD/MM/YYYY	

Note: In case any insured person(s) wish to generate his/her ABHA ID. Kindly visit the link: <https://healthid.ndhm.gov.in/register>

NOMINEE DETAILS

Nominee Name/ Appointee Name Relationship :

Relationship :

In the event of the death of an Insured Person any payment due under the Policy shall become payable to the nominee in accordance with the Policy terms and conditions. The nominee must be an immediate relative of the Proposer. For all other persons proposed to be insured, the Proposer shall be the Nominee.

PREVIOUS INSURER DETAILS

Sr No	Insured Name	Policy Holder Name	Sum Insunred	policy No	Policy Period From Date DDMMYYYY	Policy Period To Date DD/MM/YYYY	Claims in past 4 years
1.							
2.							
3.							
4.							
5.							
6.							
7.							
8.							

PROPOSAL FORM

MEDICAL AND PAST MEDICAL HISTORY

Medical History	Insurer 1	Insurer 2	Insurer 3	Insurer 4	Insurer 5	Insurer 6	Insurer 7
Have you been suffering from any illness or disease (if yes please provide details)							
Are you under any medications for any illness or injury? (If yes please provide details)							
Have you been diagnosed/hospitalised for treatment of any injury /ailment in past 4 Years? (If Yes please provide details)							
Lifestyle Details							
Do you consume Alcohol? If yes (Quantity / day) (ml/day)	Y <input type="checkbox"/> / N <input type="checkbox"/>	Y <input type="checkbox"/> / N <input type="checkbox"/>	Y <input type="checkbox"/> / N <input type="checkbox"/>	Y <input type="checkbox"/> / N <input type="checkbox"/>	Y <input type="checkbox"/> / N <input type="checkbox"/>	Y <input type="checkbox"/> / N <input type="checkbox"/>	Y <input type="checkbox"/> / N <input type="checkbox"/>
Do you Smoke? If Yes(Quantity/day) (number/day)	Y <input type="checkbox"/> / N <input type="checkbox"/>	Y <input type="checkbox"/> / N <input type="checkbox"/>	Y <input type="checkbox"/> / N <input type="checkbox"/>	Y <input type="checkbox"/> / N <input type="checkbox"/>	Y <input type="checkbox"/> / N <input type="checkbox"/>	Y <input type="checkbox"/> / N <input type="checkbox"/>	Y <input type="checkbox"/> / N <input type="checkbox"/>
Are you ever or currently addicted to any habit-forming substance? (If yes, please give details)	Y <input type="checkbox"/> / N <input type="checkbox"/>	Y <input type="checkbox"/> / N <input type="checkbox"/>	Y <input type="checkbox"/> / N <input type="checkbox"/>	Y <input type="checkbox"/> / N <input type="checkbox"/>	Y <input type="checkbox"/> / N <input type="checkbox"/>	Y <input type="checkbox"/> / N <input type="checkbox"/>	Y <input type="checkbox"/> / N <input type="checkbox"/>

Select Your Preferred Third Party Administrator (TPA) for Claim Services

Sr No	Name of TPA	Select any one TPA
1	Medi Assist Insurance TPA Private Limited	<input type="checkbox"/>
2	Paramount Health Services & Insurance TPA Pvt. Ltd	<input type="checkbox"/>
3	HealthIndia Insurance TPA Service Pvt. Ltd	<input type="checkbox"/>

Payment Details

Cheque No. /DD/Fund Transfer	Date	Bank name

SECTION 41 OF INSURANCE ACT,1938 - PROHIBITION OF REBATES

- No person shall allow or offer to allow, either directly or indirectly, as an inducement to any person to take 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 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 prospectus or tables of the insurers.
- Any person making default in complying with the provision of this section shall be punishable with fine which may extend to 10 Lakhs.

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

- I understand that the information provided by me will form the basis of 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/ 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.
- 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.
- 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.
- I/We declare and consent to the company seeking medical information from any 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 and 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.
- 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 Raheja QBE General Insurance Company Limited 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.

Communication:

- I agree to be contacted by Raheja QBE to make Welcome Calls / service calls or any other communication with respect to proposer or existing policy of Company.

Place: _____

Date: ___/___/___

Signature of Proposer: _____

Intermediary Name

Intermediary Code

PROPOSAL FORM

VERNACULAR DECLARATION

Declaration in case the proposal is filled by other than the proposer / the proposer signs in vernacular language / proposer is illiterate (to be certified by someone other than the agent / employee of the company). The content of this form and its particulars have been explained by me in vernacular to the proposer who has understood and confirmed the same.

Name of translator : _____

Place: _____

Date: ___/___/____

Name of the Proposer: _____

Place: _____

Date: ___/___/____

DECLARATION FOR COMPLIANCE WITH ANTI-MONEY LAUNDERING REGULATIONS

We _____ (Insured Named) hereby declare that the source of funds for the premium paid for obtaining this insurance cover is through legitimate funds from our Bank Account No. _____

With _____ .(Name of the Bank) _____ (Bank Branch & IFSC Code)

Place: _____

Date: ___/___/____

Signature of Proposer: _____

Please provide copy of a cancelled cheque if premium is paid through NEFT /ECS /RTGS

Please enclose one document of 'Proof of Identity and one document as 'Proof of Address' with this application.
 The following documents are accepted as:

Proof of Identity:	Proof of Address:
For Individuals	
1. Passport 2. PAN Card 3. Driver's License 4. Votes's Identity Card 5. Letter from Recognized Public Authority	1. Telephone/Mobile bill not older than six months on the date of commencement of insurance 2. Bank A/c Statement with Residential address not older than six months on the date of commencement 3. Electricity Bill 4. Ration Card 5. Valid Lease Agreement along with Rent Receipt for 3 Months preceding the date of commencement of risk 6. Employer's Certificate 7. Letter from Recognized Public Authority

I/We hereby give my/our consent to Raheja QBE General Insurance Company Limited ('the Company') to verify and obtain my/our identity/address proof as well as the identity /address proof of the insured through Central KYC Registry or UIDAI or through any other modes for the purpose of undertaking KYC.