

**Group Loan Insurance Policy**
**Proposal Form (URN- RQBGLP2122-12)**

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.

(Please fill-up this form in CAPITAL LETTERS)

|                                            |  |                    |  |
|--------------------------------------------|--|--------------------|--|
| For Official use only                      |  |                    |  |
| Sales Channel Type Broker/ Direct / Agency |  | Branch             |  |
| Intermediary Name                          |  | Intermediary Code  |  |
| Sales manager name                         |  | Sales manager code |  |

| PROPOSER DETAILS                                                                                                                                                                                       |                |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------|
| <b>Name of Master policy holder:</b>                                                                                                                                                                   |                |
|                                                                                                                                                                                                        |                |
| <b>Correspondence Address:</b>                                                                                                                                                                         |                |
|                                                                                                                                                                                                        |                |
| <b>Permanent Residence Address:</b> <input type="checkbox"/> Same as Correspondence address                                                                                                            |                |
|                                                                                                                                                                                                        |                |
| <b>GSTN No:</b>                                                                                                                                                                                        | <b>PAN No:</b> |
| <b>Fixed line of contact no.</b>                                                                                                                                                                       |                |
| <b>Mobile No.</b>                                                                                                                                                                                      |                |
| <b>Email ID</b>                                                                                                                                                                                        |                |
| <b>If any of the proposed applicant /insured is Politically exposed person (PEP) or close relative of PEP: : <input type="checkbox"/> Yes <input type="checkbox"/> No</b><br>No<br>Details if PEP yes: |                |

| POLICY DETAILS                                                                                                                 |                                                                                                   |
|--------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------|
| <b>Group type:</b>                                                                                                             | <input type="checkbox"/> Employer - Employee <input type="checkbox"/> Non-Employer Employee (NEE) |
| <b>Coverage Type:</b>                                                                                                          | <input type="checkbox"/> Fixed <input type="checkbox"/> Reducing                                  |
| <b>Sum Insured:</b>                                                                                                            | <input type="checkbox"/> Fixed <input type="checkbox"/> Graded           Rs. _____                |
| <b>Policy Period:</b>                                                                                                          | From _____ To _____                                                                               |
| <b>Do you wish to avail a physical copy of your policy documents?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No |                                                                                                   |

| Coverage Details                                   |                                                                                                                                                                                                                                                 |
|----------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Section I: Personal Accident Benefit</b>        | <b>Sum Insured (INR)</b>                                                                                                                                                                                                                        |
| 1. Accidental Death                                | <input type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                        |
| 2. Permanent Total Disablement                     | <input type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                        |
| 3. Permanent Partial Disablement                   | <input type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                        |
| 4. Dependent Child Education Benefit               | <input type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                        |
| <b>Section II:</b>                                 |                                                                                                                                                                                                                                                 |
| 1. Critical Illness (CI)                           | <input type="checkbox"/> Silver Plan (5 CI)<br><input type="checkbox"/> Gold Plan (13 CI)<br><input type="checkbox"/> Gold Plus Plan (15 CI)<br><input type="checkbox"/> Diamond Plan (20 CI)<br><input type="checkbox"/> Platinum Plan (25 CI) |
| 2. Utility Bill                                    | <input type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                        |
| <b>Section III:</b><br>Hospital Daily Cash Benefit | <input type="checkbox"/> Due to an Accident<br><input type="checkbox"/> Due to an Accident & Sickness                                                                                                                                           |
| <b>Section IV:</b><br>Loss of Job                  | <input type="checkbox"/> Three EMI<br><input type="checkbox"/> Six EMI                                                                                                                                                                          |

**INSURED DETAILS**

Please provide details of Insured Persons (Attach separate sheet with the following data elements).

*\*Mandatory fields*
*# Mandatory for NEE cases*

|                                                         | Insured 1 | Insured 2 |
|---------------------------------------------------------|-----------|-----------|
| Unique identification No./ Employee No./ Membership no* |           |           |
| Employee/Member Name (as per PAN/Aadhar)*               |           |           |
| Designation/ Category/ position                         |           |           |
| Occupation/Nature of business or work                   |           |           |
| Relationship                                            |           |           |
| Date of Birth*                                          |           |           |
| Gender*                                                 |           |           |
| Email ID#                                               |           |           |
| Mobile No.#                                             |           |           |
| Marital Status                                          |           |           |
| Present Address#                                        |           |           |
| Permanent Address                                       |           |           |
| Loan Amount*                                            |           |           |
| Loan Tenure*                                            |           |           |
| Loan Account number*                                    |           |           |

|                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|
| Loan type*                                                                                                                                                                                                                                                                                                                                                                                                                            |  |  |
| Loan Sanction date*                                                                                                                                                                                                                                                                                                                                                                                                                   |  |  |
| Name of Lender*                                                                                                                                                                                                                                                                                                                                                                                                                       |  |  |
| Branch of Lender*                                                                                                                                                                                                                                                                                                                                                                                                                     |  |  |
| Type of Loan Repayment*                                                                                                                                                                                                                                                                                                                                                                                                               |  |  |
| EMI amount (if loss of job opted*)                                                                                                                                                                                                                                                                                                                                                                                                    |  |  |
| Policy type* (Fixed/Reducing)                                                                                                                                                                                                                                                                                                                                                                                                         |  |  |
| Sum Insured*                                                                                                                                                                                                                                                                                                                                                                                                                          |  |  |
| Date of Enrolment/ Joining*                                                                                                                                                                                                                                                                                                                                                                                                           |  |  |
| Product coverage*                                                                                                                                                                                                                                                                                                                                                                                                                     |  |  |
| If the insured is Politically exposed person (PEP)*                                                                                                                                                                                                                                                                                                                                                                                   |  |  |
| Details if PEP yes                                                                                                                                                                                                                                                                                                                                                                                                                    |  |  |
| ABHA number                                                                                                                                                                                                                                                                                                                                                                                                                           |  |  |
| Nominee Name 1*                                                                                                                                                                                                                                                                                                                                                                                                                       |  |  |
| Nominee 1 DOB*                                                                                                                                                                                                                                                                                                                                                                                                                        |  |  |
| Nominee 1 share %*                                                                                                                                                                                                                                                                                                                                                                                                                    |  |  |
| Relationship of Nominee 1 with Insured*                                                                                                                                                                                                                                                                                                                                                                                               |  |  |
| Account No.*                                                                                                                                                                                                                                                                                                                                                                                                                          |  |  |
| IFSC/MICR Code*                                                                                                                                                                                                                                                                                                                                                                                                                       |  |  |
| Name of the Bank*                                                                                                                                                                                                                                                                                                                                                                                                                     |  |  |
| Account Holder Name*                                                                                                                                                                                                                                                                                                                                                                                                                  |  |  |
| Nominee Name 2 (If applicable)                                                                                                                                                                                                                                                                                                                                                                                                        |  |  |
| Nominee 2 DOB                                                                                                                                                                                                                                                                                                                                                                                                                         |  |  |
| Nominee 2 share %                                                                                                                                                                                                                                                                                                                                                                                                                     |  |  |
| Relationship of Nominee 2 with Insured                                                                                                                                                                                                                                                                                                                                                                                                |  |  |
| Account No.                                                                                                                                                                                                                                                                                                                                                                                                                           |  |  |
| IFSC/MICR Code                                                                                                                                                                                                                                                                                                                                                                                                                        |  |  |
| Name of the Bank                                                                                                                                                                                                                                                                                                                                                                                                                      |  |  |
| Account Holder Name                                                                                                                                                                                                                                                                                                                                                                                                                   |  |  |
| Appointee Name (Details to be filled only if nominee is a minor)                                                                                                                                                                                                                                                                                                                                                                      |  |  |
| Relationship of Appointee with Nominee                                                                                                                                                                                                                                                                                                                                                                                                |  |  |
| Please provide details of Pre-existing disease/s if any*                                                                                                                                                                                                                                                                                                                                                                              |  |  |
| Are you currently in good health?*                                                                                                                                                                                                                                                                                                                                                                                                    |  |  |
| Are you currently or in the past have suffered from any medical condition, impairment, chronic or critical illness and/or have you been diagnosed with any such condition, undergone medical procedures or treatments, or are you under the care of a physician or healthcare provider and/or have you been hospitalized or undergone surgery, within the last 3 years and/or are you currently taking any prescription medications?* |  |  |
| Past claims information* (if any)                                                                                                                                                                                                                                                                                                                                                                                                     |  |  |
| I hereby affirm that the information furnished in my application is correct.                                                                                                                                                                                                                                                                                                                                                          |  |  |

In the event of death of the Proposer, any payment due under the Policy shall become payable to the nominee, as per the 'Nomination' clause defined by the IRDAI and the receipt of the proceeds by such nominee would be sufficient discharge to the Company. For all other persons covered under the Policy, the Proposer will be the nominee.

In case you wish to add more nominees, please attach the list of members and nominees with this form.

Note: In case any insured person(s) wish to generate his/her ABHA ID. Kindly visit the link:

<https://healthid.ndhm.gov.in/register>

**PAYMENT DETAILS**

|                                                                        |                                                                                                                                                                                                                           |                                         |
|------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------|
| Payment Option                                                         | <input type="checkbox"/> Cheque <input type="checkbox"/> Demand Draft<br><input type="checkbox"/> Fund Transfer <input type="checkbox"/> Cash<br><input type="checkbox"/> Debit Card <input type="checkbox"/> Credit Card | Date: DD/MM/YYYY                        |
| Bank Name                                                              |                                                                                                                                                                                                                           | Amount (INR):                           |
| Amount (in words)                                                      |                                                                                                                                                                                                                           |                                         |
| Account Holder Name:                                                   |                                                                                                                                                                                                                           |                                         |
| Instrument Number:                                                     |                                                                                                                                                                                                                           | Instrument Amount:                      |
| GSTIN (If more than one GSTIN, kindly attach an annexure with details) |                                                                                                                                                                                                                           | PAN No (if premium is 1 Lac and above): |
| Frequency:                                                             | <input type="checkbox"/> Monthly <input type="checkbox"/> Quarterly <input type="checkbox"/> Half Yearly <input type="checkbox"/> Annual                                                                                  |                                         |

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

**CONSENT FOR ECS**

I wish to avail the Electronic clearing facility and hereby express my unconditional consent to debit premium for my Health insurance policy applied vide proposal form no. xxxxxxxxxxxxxxxxxxxx through participation in Electronic Clearing System (ECS).

I, understand and agree that premium amount to be debited from my account may vary due to change in age bracket of the senior most member insured under the policy, claims history in expiring policy, change in applicable premium rates by the insurer, taxes and other statutory levies as may be applicable from time to time.

(Please refer to sales brochure for approximate premium details due to change in age applicable at the time of renewal)

I, hereby declare that the particulars given are correct and complete. I understand and accept that the transaction will be effected on the due date as opted by me in this form subject to the payment of premium on the policy (provided the day is a working day). If the transaction is delayed or not effective at all for reasons of incomplete or incorrect information, I/we would not hold the user institution responsible. I/We have read all the terms and conditions as are applicable for availing of this ECS Debit service from/through the user institution and agree to discharge the responsibility expected of me/us as a participant under the scheme.

I/We also hereby authorize representative of Raheja QBE General Insurance Company Ltd. carrying this ECS Debit Mandate Form to get it verified and executed by my/our Bank.

Place:  
Date: DD/MM/YYYY

Signature of Proposer

**BANK ACCOUNT DETAILS FOR PROCESS OF REFUND**

Cheque will be issued in the name of the Proposer only.

In case of cancellation of policy, if premium was paid through credit card the refund amount would be credited to Credit Card account directly or refund will be paid through cheque. Please provide the following bank details and a copy of Cancelled Cheque if you opt for direct credit of refund/ claim into your bank account: (Cancelled Cheque should be of the same bank account in which the refund needs to be credited directly).

|                        |  |
|------------------------|--|
| Name of Account holder |  |
| Bank Name              |  |
| Branch Name            |  |
| Bank Account No        |  |
| IFSC Code              |  |
| MICR Code              |  |

Note: The Proposer agrees and undertakes to intimate in writing to Raheja QBE General Insurance Company Limited about any change in bank account details.

Place:

Date: DD/MM/YYYY

Signature of Proposer

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

1. I/ We hereby 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.
2. 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. and that there is no other information which is relevant to my application for insurance for myself or the other persons to be insured that has not been disclosed to you.
3. 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.
4. 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.
5. I/We declare and consent to the company seeking medical information from any hospital who at any time 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.

6. I agree that this proposal and the declarations shall be the basis of the contract between me and/or the other persons to be insured and Raheja QBE General Insurance Company Limited and I/We and/or the other persons to be insured agree to accept a policy, subject to the conditions prescribed by Raheja QBE General Insurance Company Limited.
7. I consent and authorize Raheja QBE General Insurance Company Limited to seek medical information from any Hospital/Medical Practitioner who has at any time attended or may attend concerning any disease or illness, which affects my physical or mental health.
8. 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.
9. I/We hereby declare that the source of funds for the premium paid for obtaining this insurance cover is through legitimate funds from our Bank Account.
10. I/We agree to be contacted by Raheja QBE to make welcome calls / Underwriting/ service calls or any other communication with respect to this proposal or an existing policy of Raheja QBE.

Date: DD/MM/YYYY

Place:

Signature of Proposer

#### INTERMEDIARY DECLARATION

I, \_\_\_\_\_ (Full Name), in my capacity as an Insurance Advisor/ Specified Person of the Corporate Agent/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 herein 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.

License No./ID (Insurance Agent / Insurance Intermediary) :

Date: DD/MM/YYYY

Place:

Signature of Insurance Agent / Intermediary

**DECLARATION WHEN THE PROPOSAL FORM IS FILLED BY A PERSON OTHER THAN THE PROPOSER/ THE PROPOSER SIGNS IN A VERNACULAR LANGUAGE/ PROPOSER IS ILLITERATE**

I hereby declare that I have read out and explained the content of this proposal form and all other connected documents incidental to availing the insurance policy from 'Raheja QBE General Insurance Company Limited' to the proposer and that he/ she confirmed that he/ she has understood the same and that he/ she agrees to abide by all the terms & conditions of the same.

I hereby declare that I have fully explained to the proposer the answers to the questions that form the basis of the contract of insurance have also explained the contents in this form to the proposer in the language known to me, that I have truly and correctly recorded the answers given by the proposer and that the proposer has affixed his/ her thumb impression on the proposal form in my presence, after fully understanding the contents thereof. Further, this declaration does not confirm issuance of policy or assumption of risk thereof.

I hereby state that the contents of the form and documents have been fully explained to me and that I have fully understood the significance of the proposed contract.

Place

Date: DD/MM/YYYY

Signature of the Proposer

**DECLARATION FOR COMPLIANCE WITH ANTI-MONEY LAUNDERING REGULATIONS**

I declare that the premium amount, corresponding to this proposal, is paid out of the legally declared and assessed sources of my/our income and not out of proceeds of crime related to any offence under the Prevention of Money Laundering Act, 2002 and rules framed thereunder.

I understand that "Raheja QBE General Insurance Company Limited" has the right to call for documents and information to establish the source of funds and has also the right to reject the said proposal or to terminate the insurance contract unilaterally and/or forfeit the premium amount, if I am found to be named in any recognized sanction list/happen to have violated any provisions of law.

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.

Place

Date: DD/MM/YYYY

Signature of the Proposer

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

| KYC documents                                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
|--------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| ➤ <b>For Companies</b>                                       | <input type="checkbox"/> Certificate of incorporation<br><input type="checkbox"/> Memorandum and Articles of Association<br><input type="checkbox"/> Permanent Account Number of the company<br><input type="checkbox"/> Resolution from the Board of Directors and power of attorney granted to its managers, officers or employees, as the case may be, to transact on its behalf<br><input type="checkbox"/> GST Certificate                                           |
| ➤ <b>For Partnership Firms</b>                               | <input type="checkbox"/> Registration certificate<br><input type="checkbox"/> Partnership deed<br><input type="checkbox"/> Permanent Account Number of the partnership firm                                                                                                                                                                                                                                                                                               |
| ➤ <b>Trusts and Foundations</b>                              | <input type="checkbox"/> Registration certificate<br><input type="checkbox"/> Trust deed<br><input type="checkbox"/> Permanent Account Number or Form No.60 of the trust                                                                                                                                                                                                                                                                                                  |
| ➤ <b>Unincorporated association or a body of individuals</b> | <input type="checkbox"/> Resolution of the managing body of such association or body of individuals<br><input type="checkbox"/> Permanent account number or Form No.60 of the unincorporated association or a body of individuals<br><input type="checkbox"/> Power of attorney granted to him to transact on its behalf (such information as may be required by the reporting entity to collectively establish the existence of such association or body of individuals) |

#### STATUTORY WARNING

#### PROHIBITION OF REBATES

(Under Section 41 of Insurance Act 1938)

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.