

PROPOSAL FORM-Health QuBE (URN: HLT/PROP/RTL/01)**GUIDELINES FOR COMPLETION OF THE FORM (To be filled by proposer)**

- Please answer all the questions fully and correctly. Where any question does not apply, please mention clearly that the same is not applicable. Insurance is a contract of Utmost Good Faith requiring the Insured not only to disclose all material facts but also not to suppress any material facts in response to the questions in the proposal form.
- Please disclose all material facts while filing in the proposal form. The Policy shall become void at the option of Insurer, in the event of any untrue or incorrect statement, misrepresentation, non-description or non-disclosure in any material particular in the proposal form/personal statement, declaration and connected documents or any material information having been withheld by the Proposer or any one acting on his behalf.
- Kindly contact the Company's Offices or Agents for any doubts or clarifications on the proposal form.
- The liability of the Company does not commence until the acceptance of the proposal has been formally intimated to the insured and the full premium has been realized by the Company.

For Official Use only

Proposal No. :

Intermediary Code :

Branch :

Intermediary Name :

Sales Channel: *Direct/Agency*

Sales Manager name & Code :

PROPOSER CUSTOMER INFORMATION

Please fill all the particulars in CAPITAL letters only

Proposer's Name (please leave a space after each part of name)

Mr./ Mrs./ Ms. : _____

Date of Birth : *DD/MM/YYYY* **Gender :** Male Female Third Gender **Marital status:** Single Married Divorced Widow**Occupation :** Salaried Self-employed Housewife Retired Others (Please Specify) _____**Occupation and Nature of Business/Work:** _____**GST Number: (If Applicable) :** *12345678912345***Nationality:** Indian NRI Others (Please specify) _____**Educational Qualification:** Lesser than matriculation Matriculation Graduate Post-graduate Other _____**Annual Income:** Less than 5 Lacs Between 5 - 10 Lacs Between 10 - 20 Lacs 20 Lacs and above**Is differently abled person?** Yes No If yes, **Type of Disability:** _____ **Disability %:** _____**PAN Card No:** *XXXXX1234X***Aadhaar No:** *XXXX-XXXX-0000*Photograph of
proposer

CKYC/Driving License/Election Card/Passport/MNREGA Card No: _____

Correspondence Address:

 _____ **Landmark:** _____

City: _____ **District:** _____ **State:** _____ **Pin code:** _____

Landline Number (with STD Code): 000- 0000000000

Mobile : 0000000000

E-mail address: _____

Permanent Residence Address: Same as Correspondence address

Landmark: _____ **City:** _____ **District:** _____

State: _____ **Pin code:** _____

Are you or any of the proposed applicants a PEP* or Family member/ Close relatives/Associates of PEPs*?
 YES NO If yes, please give details (Nature of relationship and position held by PEP):

*Politically Exposed Persons” (PEPs) are individuals who have been entrusted with prominent public functions by a foreign country, including the heads of States or Governments, senior politicians, senior government or judicial or military officers, senior executives of state-owned corporations and important political party officials.

NOMINEE DETAILS#

	1 st Nominee	2 nd Nominee	3 rd Nominee	4 th Nominee
Name of Nominee				
Date of Birth of Nominee	DD/MM/YYYY	DD/MM/YYYY	DD/MM/YYYY	DD/MM/YYYY
Percentage of Nomination	____%	____%	____%	____%
Relation with the Proposer				
Mobile No.				
Email ID				
Present Address				
Permanent Address				
Bank details				
Account No.				
IFSC/MICR Code				
Name of the Bank				
Account Holder Name				

In the event of death of the Proposer, any payment due under the Policy shall become payable to the nominee as specified above, in accordance with the Policy terms and conditions. For all other persons covered under the Policy, the Proposer will be the nominee, unless differently advised. *In case you wish to add more nominees, please attach the list# with this form.*

DETAILS OF APPOINTEE (Details to be filled only if nominee is a minor)

Name of the Appointee*	Date of Birth	Age	Relationship with Nominee
Bank details			
Account No.		IFSC/MICR Code	
Name of the Bank		Account Holder Name	

*Note: A Minor should not be declared as Appointee.

DETAILS OF THE INSURANCE PRODUCT/ PLANS

Policy Type	<input type="checkbox"/> Individual <input type="checkbox"/> Family floater
Proposed Insured	<input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Children <input type="checkbox"/> Parents
Plan Type	<input type="checkbox"/> Basic Plan <input type="checkbox"/> Comprehensive Plan <input type="checkbox"/> Super Saver Plan <input type="checkbox"/> A la carte Plan
Add on covers opted, if A La Carte plan	<input type="checkbox"/> Sub limit waiver <input type="checkbox"/> Co – Pay <input type="checkbox"/> Sub limit waiver & Co-pay
Sum Insured Opted	
Proposed policy term	<input type="checkbox"/> 1 year <input type="checkbox"/> 2 year
Proposed Start Date	DD / MM / YYYY
Do you wish to avail a physical copy of your policy documents? <input type="checkbox"/> Yes <input type="checkbox"/> No	

DETAILS OF PERSONS TO BE INSURED

Insured No.	Full Name (First, Middle, Last)	Gender (M/F/T)	Date of Birth (DD/MM/YY)	Relationship with Proposer	Height (feet / inch)	Weight (kgs)	ABHA No.
1.							
2.							
3.							
4.							
5.							
6.							

I agree to share my medical records with Raheja QBE / TPA through ABHA: Yes No

Please generate your ABHA No. by visiting the official website <https://healthid.ndhm.gov.in/register> and share the same with us.

DETAILS OF OTHER HEALTH INSURANCE POLICIES IN EXISTENCE

Are you having existing Health Policy of Raheja QBE General Insurance Company Limited or are you insured under any other Health Insurance Policy? Yes No (If YES, please provide details in the table below)

Insured name	Policy number	Period of Insurance	Sum Insured	Claims lodged during policy period (Yes/No)

MEDICAL AND LIFESTYLE INFORMATION

SECTION A: Please tick 'YES' for insured wherever applicable and provide details in Section B:

Medical History & Lifestyle details	Proposed 1	Proposed 2	Proposed 3	Proposed 4,5,6
Have you been suffering from any illness or disease	Yes/No	Yes/No	Yes/No	Yes/No
Are you under any medications for any illness or injury?	Yes/No	Yes/No	Yes/No	Yes/No
Have you been diagnosed/hospitalized for treatment of any injury /ailment in past 3 Years?	Yes/No	Yes/No	Yes/No	Yes/No
Do you consume Alcohol?	Yes/No	Yes/No	Yes/No	Yes/No
Do you Smoke?	Yes/No	Yes/No	Yes/No	Yes/No
Do you use tobacco/other products?	Yes/No	Yes/No	Yes/No	Yes/No

Section B:

Medical History & Lifestyle details	Insured 1	Insured 2	Insured 3	Insured 4	Insured 5	Insured 6
Details of illness or disease						
Details of medications for any illness or injury						
Details of disease diagnosed /hospitalization for treatment of any injury /ailment in the past 3 Years?						
Alcohol quantity in units per week (1 unit = 30 ml hard liquor/ 1 glass of wine/ 500 ml beer)	1 unit	1 unit	1 unit	1 unit	1 unit	1 unit
Smoking (cigarettes per day)						

Tobacco/Other products						
Specify number of packets per day or quantity (1 packet = 5 gms)						

 Name of usually attending physician and qualifications and address:

Please let us know if you have been ever declined the cover for your life, Critical Illness Health or Personal Accident? Yes/No

If yes, please provide details: _____

Electronic 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	<input type="text"/>
b) eIA account No:	<input type="text"/>
c) Name as appearing in eIA	<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

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

Sr. No	TPA Name	Select any one
1.	MediAssist Insurance TPA Private Limited	<input type="checkbox"/>
2.	Paramount Health Services & Insurance TPA Private Limited	<input type="checkbox"/>
3.	Health India Insurance TPA Service Private Limited	<input type="checkbox"/>

PAYMENT DETAILS

Payment Option	<input type="checkbox"/> Cheque <input type="checkbox"/> Demand Draft <input type="checkbox"/> Fund Transfer <input type="checkbox"/> Cash <input type="checkbox"/> Debit Card <input type="checkbox"/> Credit Card <input type="checkbox"/> ASBA (Application Supported by Blocked Amount)	Date: DD/MM/YYYY
Bank Name		Amount (INR):
Amount (in words)		
Account Holder Name:		
Instrument Number:	Instrument Amount:	
UPI ID (If, ASBA option is opted):		
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/ Authorized representative[#]
[#]Only applicable where proposer is a person with a disability and who has appointed an authorized representative.

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/ Authorized representative[#]

[#]Only applicable where proposer is a person with a disability and who has appointed an authorized representative.

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 hereby accord my consent to authorize 'Raheja QBE General Insurance Company' to block the applicable premium payable for the aforesaid insurance policy under the BIMA ASBA facility and debit the same from my bank account upon acceptance of this proposal. In case the proposal is not accepted, I accord my consent to debit only the expenses incurred towards medical examination, if any, and unblock the balance amount. If Amount of initial premium blocked is less than the premium to be collected, then I agree to pay the differential premium amount.
10. 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.
11. 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/ Authorized representative[#][#]Only applicable where proposer is a person with a disability and who has appointed an authorized representative.

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 Proposer/ Authorized representative[#]

[#]Only applicable where proposer is a person with a disability and who has appointed an authorized representative.

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 Proposer/ Authorized representative[#]

[#]Only applicable where proposer is a person with a disability and who has appointed an authorized representative.

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
Passport	Telephone/Mobile bill not older than six months on the date of commencement of insurance
PAN Card	Bank A/c Statement with Residential address not older than six months on the date of commencement
Driver’s License	Electricity Bill
Voter’s Identity Card	Ration Card
Letter from Recognized Public Authority	Valid Lease Agreement along with Rent Receipt for 3 Months preceding the date of commencement of risk
	Employer’s Certificate
	Letter from Recognized Public Authority

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.