Universal Sompo General Insurance Co. Ltd.

(A joint venture of Indian Bank, Indian Overseas Bank, Karnataka Bank Ltd., Dabur Investment Corp. and Sompo Japan Insurance Inc.)

Registered and Corporate Office : Office No. 103, 1st Floor, Ackruti Star, MIDC Central Road, Andheri (East), Mumbai - 400 093, Maharashtra. Tel. : 022-41659800 / 900, Email : contactus@universalsompo.com

COMPLETE HEALTHCARE INSURANCE – PROPOSAL FORM

Instructions to the fill the form

This proposal should be answered after detailed enquiry of all persons to be covered

1. You must answer all the questions in this form. If a question is not applicable, state "N/A". If more space is required to answer a question, please attach additional sheets.
2. If You have any questions concerning this proposal, please contact your insurance advisor or the Company to discuss.
3. Please fill in the Proposal Form in BLOCK LETTERS and attach a passport sized photograph of each person proposed for insurance under the Policy and write the name of the person/ sign on the photograph.

Proposer Details (Please ✓ the relevant Boxes)

You must notify us of any change of contact details so we can ensure that correspondence reaches you

Name : (First Name) (Middle Name) (Last Name)

Gender : Male ☐ Female ☐ Others ☐ Date Of Birth : Occupation :

Current Address :

City : District :

State : Pin Code :

Permanent Address :

City : District :

State : Pin Code :

Address for Communication : Current ☐ Permanent ☐ E mail :

Telephone Number : Mobile :

Height : Weight : Annual Income :

Confirmation for Issuance of e-Insurance Policy: E Insurance account no. _____ I would like to open E-Insurance account with _____ Insurance Repository.

PAN Number :

Address Proof : Aadhaar ☐ Passport ☐ Driving License ☐ Voter's Card ☐ Details

Beneficiary 1

Name : (First Name) (Middle Name) (Last Name)

Gender : Male ☐ Female ☐ Others ☐ Date of Birth : Occupation :

Relationship With The Proposer : Location :

Height : Weight : (The place where you live / will live for the majority of your time for period of cover)

Beneficiary 2

Name : (First Name) (Middle Name) (Last Name)

Gender : Male ☐ Female ☐ Others ☐ Date of Birth : Occupation :

Relationship With The Proposer : Location :

Height : Weight : (The place where you live / will live for the majority of your time for period of cover)

Beneficiary 3

Name : (First Name) (Middle Name) (Last Name)

Gender : Male ☐ Female ☐ Others ☐ Date of Birth : Occupation :

Relationship With The Proposer : Location :

Height : Weight : (The place where you live / will live for the majority of your time for period of cover)

Beneficiary 4

Name : (First Name) (Middle Name) (Last Name)

Gender : Male ☐ Female ☐ Others ☐ Date of Birth : Occupation :

Relationship With The Proposer : Location :

Height : Weight : (The place where you live / will live for the majority of your time for period of cover)

Beneficiary 5

Name : (First Name) (Middle Name) (Last Name)

Gender : Male ☐ Female ☐ Others ☐ Date of Birth : Occupation :

Relationship With The Proposer : Location :

Height : Weight : (The place where you live / will live for the majority of your time for period of cover)

Beneficiary 6

Name : (First Name) (Middle Name) (Last Name)

Gender : Male ☐ Female ☐ Others ☐ Date of Birth : Occupation :

Relationship With The Proposer : Location :

Height : Weight : (The place where you live / will live for the majority of your time for period of cover)

Please paste photograph of the proposed beneficiaries in same sequence as above :

Proposer | Beneficiary 1 | Beneficiary 2 | Beneficiary 3 | Beneficiary 4 | Beneficiary 5 | Beneficiary 6

Nominee Details

In the event of the death of a beneficiary 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. Nominee for any of the persons proposed to be insured shall be the Proposer.

Nominee Name : (First Name) (Middle Name) (Last Name)

Relationship :

Address of the Nominee :

City : District :

State : Pin Code :

If the Nominee is minor, Name and Address of Appointee and relationship with Minor:

Appointee Name : (First Name) (Middle Name) (Last Name)

Relationship :

Address of the Appointee :

City : District :

State : Pin Code :

Proposed Policy Tenure : 1 Year ☐ 2 Year ☐ 3 Year ☐

When do you want your cover to begin

Plan Details : Type Individual ☐ Family Floater ☐

Plan Basic ☐ Essential ☐ Previlage ☐

1 Lakh ☐ 2 Lakh ☐ 3 Lakh ☐ 4 Lakh ☐ 5 Lakh ☐ 6 Lakh ☐ 7 Lakh ☐ 8 Lakh ☐ 9 Lakh ☐ 10 Lakh ☐

Options under the Policy : Do you wish to upgrade your plan with any of the following benefits?

Critical Illness : Yes ☐ No ☐

If Yes, Please choose Sum Insured for Critical Illness.

1 Lakh ☐ 2 Lakh ☐ 3 Lakh ☐ 4 Lakh ☐ 5 Lakh ☐
6 Lakh ☐ 7 Lakh ☐ 8 Lakh ☐ 9 Lakh ☐ 10 Lakh ☐

For Floater Plan SI : _____

Personal Accident : Yes ☐ No ☐

If Yes, Please Choose Sum Insured for Personal Accident.

1 Lakh ☐ 2 Lakh ☐ 3 Lakh ☐ 4 Lakh ☐ 5 Lakh ☐
6 Lakh ☐ 7 Lakh ☐ 8 Lakh ☐ 9 Lakh ☐ 10 Lakh ☐

For Floater Plan SI : _____

Hospital Daily Cash : Yes ☐ No ☐

The benefits under the Hospital Daily Cash Shall be as per your choosen plan

Do you wish to get discounted premium with any of the following options?

Sublimits Applicability : Yes ☐ No ☐

If yes, please indicate your Selection. A ☐ B ☐ C ☐

Treatment only in tiered network : Yes ☐ No ☐

Please note
- Each plan and options chosen will apply to all beneficiaries
- The Sum Insured under the chosen plan and options need not be indentical.
- Your plan selection can only be amended at policy renewal. Should you wish to increase your level of cover at renewal, full medical underwriting and waiting periods may apply and an additional premium amount will be payable.

Existing / Previous Insurance Details

Are you or the beneficiaries already insured under a plan with us or any other insurance company? Yes ☐ No ☐

If yes, please indicate below the Policy/Application number(s) (Please mention application number incase of pending proposal)

Since when are you continuously insured?

Do you want us to consider these details for continuity? Yes ☐ No ☐

Policy No/ Application No. Insurer	Period of Insurance From	To	Sum Insured	Claims lodged during preceding years

Please note that continuity of benefits shall NOT be considered if the above question of want of continuity is not replied affirmative, details are not provided and Portability form and relevant supporting documents are not submitted.

Has any application for life, health, hospital daily cash or critical illness insurance ever been declined, postponed, loaded or been made subject to any special conditions by any insurance company for you or any of the beneficiaries ? Yes ☐ No ☐

If yes, please provide details as below

Name of the beneficiary this relates to	Year in which the cover was declined?	Name of the Company	Type of cover declined	Reasons for declination (if known)

Medical And Lifestyle Declaration

Please tell us about past and present medical and lifestyle history for yourself and all other persons to be covered under the policy. Once you've done this we can finalise your application. It may help to have any relevant medical documentation to hand when you are filling out this form

Depending on the medical history, we might need some further information before we can finalise your cover.

Please read the following questions very carefully and answer each question accurately. Failure to disclose all material facts could affect payment of claims under the policy and may result in us terminating your cover

A material fact is one which we may want to take into account when considering your application. If you are in any doubt as to whether a fact is material, then you should disclose it.

If you are unsure about the answer to any question you should make the enquiries necessary to allow you to provide an accurate answer.

The obligation to notify us of all material facts continues to apply beyond the start date of your policy. This means that if the answers to any of the following questions change, you must notify us immediately.

When answering the questions below, please answer them for yourself and ALL other persons to be covered by this policy.

Medical History

Has any of the person proposed to be insured ever suffered from/ are currently suffering from any of the following:

1 High or low blood pressure, Chest Pain, or any other cardiac disorder — Yes ☐ No ☐
2 Tuberculosis, Asthma, Bronchitis or any other lung/respiratory disorder — Yes ☐ No ☐
3 Ulcer(Stomach/Duodenal), Liver or gall bladder disorder or any other digestive tract disorder — Yes ☐ No ☐
4 Kidney Failure, Stone in kidney or urinary tract, Prostate disorder or any other kidney/urinary tract disorder — Yes ☐ No ☐
5 Stroke, Epilepsy (fits), Paralysis or any other nervous system (Brain, Spinal cord, etc) disorder — Yes ☐ No ☐
6 Diabetes, Impaired glucose tolerance (Pre-diabetes), Thyroid/Pituitary Disorder or any other endocrine disorder — Yes ☐ No ☐
7 Tumor (Swelling)-benign or malignant, any external ulcer/growth/cyst/mass anywhere in the body — Yes ☐ No ☐
8 Arthritis, Spondylosis or any other disorder of the muscle/bone/joint — Yes ☐ No ☐
9 Diseases of the Ear/Nose/Throat/Teeth/ Eye (please mention Dioptres in case of refractory error) — Yes ☐ No ☐
10 HIV/AIDS or sexually transmitted diseases or any immune system disorder — Yes ☐ No ☐
11 Anaemia, Leukaemia, Lymphoma or any other blood/lymphatic system disorder — Yes ☐ No ☐
12 Psychiatric/Mental illnesses or Sleep disorder — Yes ☐ No ☐
13 Uterine Fibroid, Fibroadenoma breast or any other Gynaecological (Female reproductive system)/Breast disorder — Yes ☐ No ☐

Lifestyle information : Has any of the persons proposed to be insured:

14 Been addicted to alcohol, narcotics, habit forming drugs or been under detoxication therapy? — Yes ☐ No ☐
15 Been under any regular medication (self/ prescribed)? — Yes ☐ No ☐
16 Undertaken any lab/blood tests, imaging tests viz. scans/MRI in the last 5 years other than routine health check-up or pre-employment check-up? — Yes ☐ No ☐
17 Undertaken any surgery or a surgery been advised and have surgery still pending? — Yes ☐ No ☐
18 Suffered from any other disease/illness/accident/injury other than common cold or fever? — Yes ☐ No ☐

Pregnancy Information

19 Is anyone currently pregnant? If yes, please mention expected date of delivery ☐☐ ☐☐ ☐☐☐☐ — Yes ☐ No ☐
20 Any complaint of diabetes, hypertension or any complication during current or earlier pregnancy? — Yes ☐ No ☐

If you answered "Yes" to any of the questions in Medical History above, then please provide details in the table below

Question Number	Name of the beneficiary this related to	Symptoms/ Conditions/ Diagnosis	Date of onset	Frequency and Severity of symptoms	Date of last episode/ symptom	Details of any past or current medication or treatment	Current Stats (e.g. fully recovered/ on-going)	Doctor/ Hospital Name and Phone Number

Payment details

Instrument Type : Cash ☐ Cheque ☐ Debit Card ☐ Credit Card ☐ Other

Name of the Bank :

Name of the premium payer :

Branch :

Account Number :

Account Type : Current ☐ Savings ☐ Date ☐☐ ☐☐ ☐☐☐☐ Amount

Please make a A/C Payee Cheque/DD/Pay Order in favour of 'Universal Sompo General Insurance Company Limited' only.

Additional Information

(If there is insufficient space to provide additional relevant information, whether as requested or otherwise, please attach extra sheet duly signed.)

Medical Examination

We may ask You or any of the beneficiaries to undergo below mentioned medical tests for purpose of consideration of Your proposal in the following events

- You or any of the beneficiaries is/are above 55 years of age as on Your last birthday.
- On basis of above medical conditions/ health status declaration.

S. N.	List of Medicals Tests	Plan
1	Complete Blood Count, Urine Routine, Blood Group, ESR, Fasting Blood Glucose, S Cholesterol, SGPT, Creatinine	Basic
2	Complete Blood Count, Urine Routine, Blood Group, ESR, Fasting Blood Glucose, S Cholesterol, SGPT, Creatinine, ECG.	Essential
3	Complete Blood Count, Urine Routine, Blood Group, ESR, Fasting Blood Glucose, S Cholesterol, SGPT, Creatinine, ECG, Lipid Profile, Stress test or 2D Echo , Kidney Function Test, Complete Physical test by a physician	Privilage

It is agreed and understood that details in the table above, including the list of medical tests is indicative and we reserve the right to add, to modify or amend these details.
If the proposal is accepted by us, then 50% of the costs incurred in conducting the above mentioned medical tests shall be reimbursed by us.
We may waive such requirement of undergoing Medical Examination if you and/ or the beneficiaries have been continuously covered for 3 years under a health insurance policy from us or any one of the Indian Insurer and have had no claims under the policy.

AML GUIDELINES :

1. I/we hereby confirm that all premium have/will be paid from bonafide sources and no premium have been/will paid out of proceeds of crime related to any of the offence listed in prevention of Money Laundering Act, 2002.
2. I understand that the Company has the right to call for documents to establish sources of funds.
3. The insurance company has right to cancel the insurance contract in case I am/have been found guilty by any competent court of law under any of the statutes, directly or indirectly governing the prevention of money laundering in India.

Nationality : Indian ☐ Non-Indian ☐ If Non-Indian, Please specify the Country _____

Type of Organization :

Corporations ☐ Governments ☐ Non Governmental Organizations ☐ Society ☐
Trust ☐ Partnership ☐ International Organization ☐ Cooperative ☐ Section 25 Company ☐

Debit Authorization for Current & Future Renewal Premiums

I hereby authorize Bank to debit my account number ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ with the bank for Rs. _____

towards first premium for availing the said Universal Sompo Health Insurance Cover.

☐ I hereby request and authorize the Bank to debit my account number ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ on the yearly due dates with the applicable renewal premium.

Declaration

1. "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.
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.
3. 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.
4. 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.
5. I/We declare and consent to the company seeking medical information from any doctor or from a hospital who at anytime has attended on the life to be insured/proposer or from any past or present employer concerning anything which affects the physical or mental health of the life to be assured/proposer and seeking information from any insurance company to which an application for insurance on the life to be assured/proposer has been made for the purpose of underwriting the proposal and/or claim settlement.
6. 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."

Date : ☐☐ ☐☐ ☐☐☐☐ Signature of the Proposer : _____

Place : ☐☐☐☐☐☐☐☐ Name of the Proposer : _____

Vernacular Declaration

I hereby declare that I have fully explained the contents of the Proposal Form and all other documents incidental to availing the health insurancefrom Universal Sompo General Insurance Company Limited to the Proposer in the language understood by him/her. The same have been fullyunderstood by him/her and the replies have been recorded as per the information provided by the Proposer and the replies have been read out to fully understood and confirmed by the Proposer.

Declarant's Name : _____

Relationship with the proposer : _____

Date : ☐☐ ☐☐ ☐☐☐☐ Place : _____

Signature of Declarant : _____ Signature of Applicant in vernacular: _____

Agent's declaration

I,_____ in my capacity as an InsuranceAdvisor/ Specified Person of the Corporate Agent/Authorised 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 favour 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. (Advisor/Corporate Agent/Broker/Relationship Offcer) : ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Date : ☐☐ ☐☐ ☐☐☐☐ Place : _____ Signature of Agent : _____

Checklist

- Please check the following documents are attached along with the proposal form
- ID Proof : Passport/ PAN Card/ Voter ID/ Driving License/ Letter from a recognized public authority
- Proof of residence: Telephone Bill/ Bank Account Statement/ Letter from any recognized public authority/Electricity Bill/ Ration Card
- Age Proof: Proof of Age
- Renewal Notice with claim details
- Certification of previous insurer for previous claim details
- Photocopies of all previous policies and endorseemnts

For Official Use Only

Universal Sompo Health Office Code _____ Advisors Code & Name: _____

Branch Receipt Date: ☐☐ ☐☐ ☐☐☐☐ Channel Type : _____ Business type: Urban ☐ Rural ☐ Social ☐

Section 41 of Insurance Act 1938 (Prohibition of rebates)

1) 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.
2) Any person making default in complying with the provisions of this section shall be punishable with fine which may extend toTen lakh rupees.

Universal Sompo General Insurance Co. Ltd.

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