DIGIT HEALTH CARE PLUS POLICY
PROPOSAL FORM
UIN: GODHLIP21486V022021
URN: GODT/IND/HL/1920/01

a. This proposal will be the basis of the insurance policy that we issue. You must disclose all facts relevant to all person(s)/asset(s) proposed to be insured that may affect the Company's decision to issue a policy or its terms. Non-compliance may result in avoidance of the policy.
b. If there is insufficient space for you to provide information, whether as requested or otherwise, please attach a separate sheet duly signed or affixed with thumb impression.
c. In case You agree not to receive the hard copy of the Policy and related documents, please provide Your Consent: Yes/No
If You opt not to receive the hard copy of the Policy and related documents, we shall share these with You is Electronic Form I.e. Via E-mail or Direct Download from Our Website.
d. Please submit KYC documents along with the Proposal Form, if applicable.
e. If you are in doubt, you can get in touch with your agent/intermediary or call us at 1800 103 4448 or e-mail at hello@godigit.com

For Office Use only: **For Distributor Use Only:**

Proposal No	Receipt No	Policy No	IMD Code	Sub IMD Code	IMD Name

PROPOSER DETAILS

Full Name		**Date of Birth (DD/MM/YY)**			
Address of the Proposer		**Marital Status**	Single / Married		
Mobile No		**Occupation**	Salaried / Self Employed / Professional / Other		
Email ID		***Period of Insurance**	From	DDMMYYYY	00:01 Midnight
Partner Code and Name			To	DDMMYYYY	00:01 Midnight
Partner Contact and Email ID		**Policy Type**	Individual / Floater		

***Period of Insurance can be for 1 Year / 2 Years or 3 Years.**

DETAILS OF PERSONS TO BE INSURED

Member. No.	Full Name	Relationship with Proposer	Date of Birth (DD/MM/YY)	Age	Gender (M/F)	Height	Weight	Occupation	Nominee/Assignee Name	Nominee/AssigneeRelationship with Insured
1										
2										
3										
4										
5										

COVERAGE DETAILS

Section with Benefits	Sum Insured (INR)	Limits	Waiting Periods	Deductible (INR) / Co-Payment (%)	Specific Conditions
SECTION 1-HOSPITALIZATION COVER					
A. Accidental Hospitalization Cover	INR	Accommodation/Room Rent: ___% of Section 1.A Sum Insured	NA		
A1. Day Care Procedures	*Inbuilt	NA			
A2. Pre-Hospitalization Expenses	*Inbuilt	Up to _____ Days			
A3. Post-Hospitalization Expenses	*Inbuilt	Up to _____ Days OR Onetime Lumpsum Benefit: _____% of the Claim Amount Approved under Section 1. A.			
A4. Dental Treatment	*Inbuilt	NA			

A5. Road Ambulance	*Inbuilt	1% of Section 1.A Sum Insured Max up to the INR 5000			
A6. Second Medical Opinion	*Inbuilt	NA			
CUMULATIVE BONUS	INR_____				
B. Accidental & Illness Hospitalization Cover	INR	Accommodation/Room Rent: ___% of Section 1.B Sum Insured			
B1. Day Care Procedures	**Inbuilt	NA			
B2. Pre-Hospitalization Expenses	**Inbuilt	Up to _____ Days			
B3. Post-Hospitalization Expenses	**Inbuilt	Up to _____ Days OR Onetime Lumpsum Benefit: _____% of the Claim Amount Approved under Section 1. B.	A. Initial Waiting Period: _____ Days B. Pre-existing Disease: _____Months C. Specific Waiting Period: _____Months		
B4. Dental Treatment	**Inbuilt	NA			
B5. Road Ambulance	**Inbuilt	1% of Section 1.B Sum Insured Max up to the INR 5000			
B6. Bariatric Surgery Cover	**Inbuilt	____% of Section 1.B Sum Insured			
B7. Psychiatric Illness Cover	**Inbuilt	____% of Section 1.B Sum Insured Up to 1 Lakh			
B8. Complimentary Health Check Up	Over and Above the Sum Insured	Up to 0.25% OR 0.5% of the Sum Insured (excluding any cumulative bonus) Subject to maximum of INR 5,000 Per Policy			
B9. Second Medical Opinion	*Inbuilt	NA			
CUMULATIVE BONUS	INR_____				
SECTION 2. INFERTILITY TREATMENT COVER	**Inbuilt	10% of the Section 1.B Sum Insured	_____ Months		
SECTION 3. ORGAN DONOR	**Inbuilt	NA	As mentioned under Section 1. B.		
SECTION 4. ALTERNATE TREATMENT (AYUSH) COVER	**Inbuilt	NA	As mentioned under Section 1. B.		
# SECTION 5. EMERGENCY AIR AMBULANCE	*Inbuilt and/or **Inbuilt	NA	NA		
SECTION 6. LONG HOSPITALIZATION CASH BENEFIT	INR	Minimum _____ Days Hospitalization	-		
SECTION 7. MATERNITY BENEFIT & NEW BORN BABY COVER	INR	Limit on Maternity Expenses of Your Second Child: _____% of the Sum Insured under this Section	_____ Months		
SECTION 8. OUT-PATIENT (OPD) BENEFIT	INR	NA	As mentioned under Section 1. A. and/or Section 1. B.	Basis 1: Co-Payment of 25% in the First Year of this Section being opted, 10% on First Renewal this Section and No Co-payment from the Second Renewal of this Section Basis 2: Nil Co-payment	
SECTION 9. HOME (DOMICILIARY) HOSPITALIZATION	**Inbuilt	NA	As mentioned under Section 1. A. and/or Section 1. B.		
SECTION 10. SUM INSURED REFILL BENEFIT	Yes/No	Once During Policy Period / Unlimited Times	NA		
SECTION 11. DAILY HOSPITAL CASH COVER					
A. Accidental Hospitalization Cover	INR____Per Day	Up to _____ Days	NA		Time Excess : _____ Days
B. Accidental & Illness Hospitalization Cover	INR____Per Day	Up to _____ Days	Initial Waiting Period: _____ Days Pre-existing Disease: _____Months Specific Waiting Period: _____Months		Time Excess : __ Days

SECTION 12. CRITICAL ILLNESS BENEFIT COVER	INR	NA	Initial Waiting Period: ____ Days		
SECTION 13. CRITICAL ILLNESS HOSPITALIZATION COVER	INR	Accommodation/Room Rent: ___% of Section 13 Sum Insured	Initial Waiting Period: _____ Days		
CUMULATIVE BONUS	INR_____				
SECTION 14. CANCER BENEFIT COVER	INR	NA	Initial Waiting Period: ____ Days		
SECTION 15. CANCER HOSPITALIZATION COVER	INR	Accommodation/Room Rent: ___% of Section 15 Sum Insured	Initial Waiting Period: _____ Days		
CUMULATIVE BONUS	INR_____				
SECTION 16. WELLNESS BENEFIT PROGRAM	NA	Services Opted: Doctor On Call / Wellness Coach / Lab Services (Home Collection) Etc			

Note: You can choose either one of the below covers or both the covers:

- Section 1.A. Accidental Hospitalization Cover
- Section 1.B. Accidental & Illness Hospitalization Cover

1. If You are opting only for Section 1.A, then coverage is only for Accidental Hospitalization.
2. If You are only for Section1.B, then coverage is for both Illness and Accidental hospitalization.

Example:

If You are opting for both Section 1.A and 1.B and assuming Sum insured for Section 1.A is 1 Lakh and Section 1.B is 4 Lakhs, You are eligible for Maximum Single Claim of 5 lakhs for Accidental Hospitalisation and Maximum Single Claim of 4 lakhs for Hospitalisation due to Illness, however aggregate Sum Insured will be limited to 5 Lakhs for the Policy Period.

Section 5. Emergency Air Ambulance can be opted only where Section 1.A. Accidental Hospitalization Cover and/or Section 1.B. Accidental & Illness Hospitalization Cover Sum Insured exceeds INR 3 Lakhs.

PREMIUM PAYMENT ZONE & GEOGRAPHICAL LIMITS

Premium Payment Zone: ☐ Zone A ☐ Zone B ☐ Zone C

Based on your city of residence, Zones have been classified into three as mentioned below:
Zone A: Delhi/NCR, Mumbai including (Navi Mumbai, Thane and Kalyan).
Zone B: Hyderabad and Secunderabad, Bangalore, Kolkata, Ahmedabad, Vadodara, Chennai, Pune and Surat.
Zone C: Rest of India apart from Zone A and Zone B cities are classified as Zone C.
Note: In case of family floater policies, a single zone shall be applied to all the members covered under the policy.

Note:

1. If You have availed choice of Zone B at the time of Policy Inception and availing treatment in a Hospital which is situated in Zone A, 10% Co-pay would be applicable on admissible claim amount.
2. If You have availed choice of Zone C at the time of Policy Inception and availing treatment in a Hospital which is situated in Zone B, 10% Co-pay would be applicable on admissible claim amount.
3. If You have availed choice of Zone C at the time of Policy Inception and availing treatment in a Hospital which is situated in Zone A, 20% Co-pay would be applicable on admissible claim amount.

Geographical Limits:

Geographical Limits Options	☐ Within India ☐ Asia ☐ Worldwide Including USA & Canada ☐ Worldwide Excluding USA & Canada
Options for Co-Payment where Geographical Limit is Outside India	☐ 0 % ☐ 5 % ☐ 10 % ☐ 15% ☐ 20%

MEDICAL HISTORY

Have any of the person proposed to be insured ever suffered from / are suffering from any of the following and/or having any of the habits mentioned below: Please tick 'YES" for insured wherever applicable and provide details in the table below:

Sr. No.	Medical History / Habits	Yes/No	Please Tick the "Member Number "who had/having mentioned Medical History/Habits					Diagnosis Since (In Years)				
1	Are you taking any medicines, prescribed or otherwise?		1	2	3	4	5	Up to 1	2	3	4	> 4

2	Any history of consultation or hospitalization (including day care) in last 4 years (other than uneventful maternity/delivery in case of female customer)		1	2	3	4	5	Up to 1	2	3	4	> 4
3	Any diagnostic tests like Blood/ECG/ECHO/CT or MRI Scan etc., in last 4 years other than preventive health check up with normal reports		1	2	3	4	5	Up to 1	2	3	4	> 4
4	Do you have undiagnosed symptoms like chest pain, weakness, weight loss, dizziness, joint pain, change in bowel habit, difficulty in breathing, pain in abdomen, bleeding/pain while passing stools?		1	2	3	4	5	Up to 1	2	3	4	> 4
5	Have you or any member of your family proposed to be insured, suffered or suffering from any disease/ailment/adverse medical condition of any kind especially Heart/Stroke/Cancer/Renal disorder/Joint/Gastrointestinal disease/Respiratory /neurological / endocrine / blood related disorder		1	2	3	4	5	Up to 1	2	3	4	> 4
6	Is there any other information relating to your health that has not been prompted by the questions listed above?		1	2	3	4	5	1 Up to 1	2	3	4	> 4
7	Was any proposal for life, health, hospital daily cash or critical illness insurance declined, deferred, withdrawn or accepted with modified terms		1	2	3	4	5	Up to 11	2	3	4	> 4
8	Do you Smoke tobacco		1	2	3	4	5	Up to 1	2	3	4	> 4
9	Do you Chew tobacco		1	2	3	4	5	Up to 1	2	3	4	> 4
10	Do you Consume Alcohol		1	2	3	4	5	Up to 1	2	3	4	> 4

Any additional details with respect to the questions answered "Yes" in the above table:

Member Number	Details of Illness with Symptoms	Date of Last Consultation	Treatment Details with Treating Doctor Details	Result of the Treatment (Ongoing/Complete Recovery/ Recurrent or like to Recur)
Member Number 1				
Member Number 2				
Member Number 3				
Member Number 4				
Member Number 5				

PREMIUM PAYMENT DETAILS

Cheque No/NEFT Ref No	Bank Name	Date	Amount (Including applicable taxes)

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

- I hereby declare, on my behalf and on behalf of all persons proposed to be insured, that the above statements, answers and/or particulars given by me are true and complete in all respects to the best of my knowledge and that I am authorized to propose on behalf of these other persons.
- 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 insurer and that the policy will come into force only after full payment of the premium chargeable.
- I further declare that I will notify in writing any change occurring in the occupation or general health of the life to be insured/proposer after the proposal has been submitted but before communication of the risk acceptance by the company.
- I declare that I consent to the company seeking medical information from any doctor or hospital who/which at any time has attended on the person to be insured/proposer or from any past or present employer concerning anything which affects the physical or mental health of the person to be insured/proposer and seeking information from any insurer to whom an application for insurance on the person to be insured /proposer has been made for the purpose of underwriting the proposal and/or claim settlement.
- I authorize the company to share information pertaining to my proposal including the medical records of the insured/proposer for the sole purpose of underwriting the proposal and/or claims settlement and with any Governmental and/or Regulatory authority."

****Please read declaration wordings carefully before signing the proposal form**.

Date:

Signature of the Proposer

Place:

Declaration from Person filling the form in case proposer is unable to sign or signs in vernacular:
I hereby certify that the contents of the proposal form and/or any other documents used towards solicitation have been fully explained to the Proposer and that he/ she/they have fully understood the said contents. I hereby confirm that the responses have been recorded to the best of my ability.

Date:

Place:

Signature (on behalf of the Proposer)

Name & Relationship with Proposer:

INSURANCE ACT 1938 SECTION 41- Prohibition of Rebates

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 a policy accept any rebate, except such rebate as may be allowed in accordance with the published prospectus or tables of the insurer. ANY PERSON MAKING FAULT IN COMPLYING WITH THE PROVISIONS OF THIS SECTION SHALL BE PUNISHABLE WITH FINE WHICH MAY EXTEND TO TEN LAKHS RUPEES.

Go Digit General Insurance Ltd, A Company incorporated under Indian Companies Act, 2013 and licensed by Insurance Regulatory and Development Authority of India [IRDAI] vide Reg No. 158, Corporate Identification Number U66010PN2016PLC167410, Reg. Address Atlantis, 95, 4th B Cross Road, Koramangala Industrial Layout, 5th Block, Bengaluru 560095. Website: www.godigit.com