

GALAXY MARVEL / GALAXY COMPANION (RIDER)

UIN:GHIHLIP26042V012526

UIN:GHIHLIA26047V012526

PLEASE FILL UP THE PROPOSAL FORM IN BLOCK LETTERS

Proposal Reference No.:	Policy No.:
Policy issuing office:	Fresh or Portability:

NAME OF AGENT / CORPORATE AGENT / BROKER / IMF / POSP:	POSP PAN Number:
CODE OF AGENT / CORPORATE AGENT / BROKER / IMF / POSP:	POSP GST Number:
BUSINESS DEVELOPMENT MANAGER NAME & CODE:	

Proposer Details	
Proposer Name (Same as per KYC/ID Proof) _____	
Name of Father / Mother / Spouse / Maiden _____	
DOB:	Gender: ☐ Male ☐ Female ☐ Transgender
Marital Status: _____	
Occupation _____	
Do you have CKYC ☐ Yes ☐ No	
If Yes, CKYC Number _____ If No, Please submit your Photo, Address Proof and ID Proof	
PAN Number _____ or Form 60 [If PAN number is not available submit Form 60]	
Source of Income (Salaried / Business / If others, please specify) _____ Annual Income: (Rs) _____	
Are you a PEP - Politically Exposed Person or any Insured members is PEP or related to PEP? If Yes, share more details. _____	
Residential Status ☐ Indian Resident ☐ Non Resident Indian ☐ Person of Indian Origin ☐ Foreign National	
GST Number _____	
Specify the submitted ID and Address Proof _____	

Current Address	Permanent Address (should be same as Address Proof)
_____	_____
_____	_____
City / Town / Village _____	_____
District _____	_____
State _____	_____
Country _____	_____
Pin Code _____	_____
Mobile Number _____	_____
E Mail ID _____	_____

Bank Details of the Proposer	
Bank A/C No: _____	Name of the Bank: _____
IFSC Code: _____	Branch Name: _____
Type of A/C (Savings or current or Others Please Specify): _____	

Do you wish to receive your insurance policy and all the information related to the proposed insurance policy through insurance repository ☐ Yes ☐ No

If yes, EIA number: _____

If you don't have an (EIA) number, please choose any one insurance repository

☐ CAMS Insurance Repository Services Limited or ☐ CDSL Insurance Repository Limited or ☐ NSDL National Insurance Repository (NIR)

Nominee Details	
Nominee's Name _____	Relationship with the Proposer _____ DOB: _____ Age: _____
Appointee's Name _____	Relationship with the Nominee _____ DOB: _____ Age: _____
(If nominee is minor)	
In case of Multiple nominees a separate form containing nominee details should be enclosed duly specifying the % to each nominee	
E Mail ID _____	Mobile Number _____
Current Address _____	
Permanent Address _____	

Bank Details of the Nominee	
Bank A/C No: _____	Name of the Bank: _____
IFSC Code: _____	Branch Name: _____
Type of A/C (Savings or current or Others Please Specify): _____	

Unique No.: GHI/PO12,GHI/PO22

GALAXY HEALTH INSURANCE COMPANY LIMITED

Registered Office: "Prestige Polygon", 12th Top Floor (P), #471, Anna Salai, Nandanam, Chennai - 600 035 • T: 044 - 4001 7227

Website: www.galaxyhealth.com • IRDAI Registration No. 167 • CIN No. U65120TN2023PLC165765 • GST No. 33AAKCG8906A1ZU

Period of Insurance: From _____ to _____

Policy Term Opted: ☐ 1Year ☐ 2Years ☐ 3Years ☐ 4Years ☐ 5Years

Plan Name: ☐ Neo ☐ Prime

Mode of Payment: ☐ Cheque ☐ DD ☐ Debit Card ☐ Credit Card

☐ NEFT ☐ QR ☐ UPI ☐ CC Mandate ☐ Cash

(Cash payments are not eligible for 80D tax benefits)

Social Sector Classification: ☐ Yes ☐ No

Policy Opted (Policy Type): ☐ Individual ☐ Floater

Sum Insured for Floater Basis (Rs. in lakhs):

☐ 5L ☐ 7.5L ☐ 10L ☐ 15L ☐ 20L ☐ 25L ☐ 1Cr ☐ 2Cr

Family Size: ☐ 1A ☐ 1A+1C ☐ 1A+2C ☐ 1A+3C

☐ 2A ☐ 2A+1C ☐ 2A+2C ☐ 2A+3C

Galaxy Companion (Rider)

(UIN: GHIHLIA26047V012526)

☐ No ☐ Silver ☐ Gold ☐ Platinum ☐ Diamond

Insured Person Details

S.No	Particulars	Insured Person 1	Insured Person 2	Insured Person 3	Insured Person 4	Insured Person 5
1	Name					
2	Gender					
3	DOB					
4	Height (cms)					
5	Weight (kgs)					
6	Relationship with Proposer					
7	Occupation					
8	ABHA No.*					
9	No Claim Benefit (Bonus/NCD)	☐ Bonus ☐ NCD	☐ Bonus ☐ NCD	☐ Bonus ☐ NCD	☐ Bonus ☐ NCD	☐ Bonus ☐ NCD
10	Sum Insured (If Individual SI basis)					
11	Are you a NRI/OCI# If yes, please submit Address proof	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

12 Details of Family Member (Applicable for Galaxy Companion - Rider)

1. Name of the Family Member:

2. Contact details of the Member:

4. Email Id:

3. Relationship with the Proposer:

5. Country of Stay:

13 Do you want to choose optional covers listed below

1	Insta Care Cover from 31st day (Asthma/BP/Cholesterol/Diabetes) If Insured Person has ticked Diabetes, Please state the level of Diabetes	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
2	Enhanced Multiplier (3X or 10X)	☐ No ☐ 3X ☐ 10X	☐ No ☐ 3X ☐ 10X	☐ No ☐ 3X ☐ 10X	☐ No ☐ 3X ☐ 10X	☐ No ☐ 3X ☐ 10X
3	Premium Promise (Applicable only for Neo Plan)	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
4	Consumables (Applicable only for Neo Plan)	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
5	Partner Protect	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
6	Delivery Expenses	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

Do you want to pay the premium in Installments ☐ Yes ☐ No

If yes (Please select (✓) Installment Premium Frequency Options)

Policy Term	1	2	3	4	5
Monthly	12	24	36	48	60
Quarterly	4	8	12	16	20
Half-yearly	2	4	6	8	10
2 Installments	NA	2*	2*	2*	2*
4 Installments	NA	4*	4*	4*	4*
12 Installments	NA	12*	12*	12*	12*
Annual	NA	2#	3#	4#	5#

* Premium shall be paid within the first year of policy period

Premium shall be paid Annually for long term policies

S.No	Particulars	Insured Person 1	Insured Person 2	Insured Person 3	Insured Person 4	Insured Person 5
7	Assisted Reproduction Treatment	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
8	High end diagnostics	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
9	Wealth for Health	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
10	Outpatient Benefit	☐ Silver ☐ Gold ☐ Platinum ☐ Diamond ☐ No	☐ Silver ☐ Gold ☐ Platinum ☐ Diamond ☐ No	☐ Silver ☐ Gold ☐ Platinum ☐ Diamond ☐ No	☐ Silver ☐ Gold ☐ Platinum ☐ Diamond ☐ No	☐ Silver ☐ Gold ☐ Platinum ☐ Diamond ☐ No
11	Air Ambulance	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
12	Accidental Death and Permanent Total Disablement	☐ Yes ☐ No Sum Insured	☐ Yes ☐ No Sum Insured	☐ Yes ☐ No Sum Insured	☐ Yes ☐ No Sum Insured	☐ Yes ☐ No Sum Insured
13	Health check-up	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
14	Assisted Living	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
15	Nursing at Home	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
16	Durable Medical Equipment/CAPD	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
17	Compassionate Travel	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
18	Preferred Partner Network	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
19	Reduction in Pre-Existing Diseases (PED) waiting period (Applicable for Neo Plan)	☐ 2 Years ☐ 1 Year ☐ No	☐ 2 Years ☐ 1 Year ☐ No	☐ 2 Years ☐ 1 Year ☐ No	☐ 2 Years ☐ 1 Year ☐ No	☐ 2 Years ☐ 1 Year ☐ No
20	Reduction in Pre-Existing Diseases (PED) waiting period (Applicable for Prime Plan)	☐ 1 Year ☐ No	☐ 1 Year ☐ No	☐ 1 Year ☐ No	☐ 1 Year ☐ No	☐ 1 Year ☐ No
21	Reduction in Specific Disease Waiting Period	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
22	Room Rent Modification	☐ No ☐ Single Private A/c Room ☐ Shared Accommodation ☐ General Ward	☐ No ☐ Single Private A/c Room ☐ Shared Accommodation ☐ General Ward	☐ No ☐ Single Private A/c Room ☐ Shared Accommodation ☐ General Ward	☐ No ☐ Single Private A/c Room ☐ Shared Accommodation ☐ General Ward	☐ No ☐ Single Private A/c Room ☐ Shared Accommodation ☐ General Ward
23	Voluntary Aggregate Deductible	☐ No ☐ Rs. 10,000/- ☐ Rs. 25,000/- ☐ Rs. 50,000/- ☐ Rs. 1,00,000/- ☐ Rs. 2,00,000/- ☐ Rs. 3,00,000/- ☐ Rs. 4,00,000/- ☐ Rs. 5,00,000/- ☐ Rs. 10,00,000/-	☐ No ☐ Rs. 10,000/- ☐ Rs. 25,000/- ☐ Rs. 50,000/- ☐ Rs. 1,00,000/- ☐ Rs. 2,00,000/- ☐ Rs. 3,00,000/- ☐ Rs. 4,00,000/- ☐ Rs. 5,00,000/- ☐ Rs. 10,00,000/-	☐ No ☐ Rs. 10,000/- ☐ Rs. 25,000/- ☐ Rs. 50,000/- ☐ Rs. 1,00,000/- ☐ Rs. 2,00,000/- ☐ Rs. 3,00,000/- ☐ Rs. 4,00,000/- ☐ Rs. 5,00,000/- ☐ Rs. 10,00,000/-	☐ No ☐ Rs. 10,000/- ☐ Rs. 25,000/- ☐ Rs. 50,000/- ☐ Rs. 1,00,000/- ☐ Rs. 2,00,000/- ☐ Rs. 3,00,000/- ☐ Rs. 4,00,000/- ☐ Rs. 5,00,000/- ☐ Rs. 10,00,000/-	☐ No ☐ Rs. 10,000/- ☐ Rs. 25,000/- ☐ Rs. 50,000/- ☐ Rs. 1,00,000/- ☐ Rs. 2,00,000/- ☐ Rs. 3,00,000/- ☐ Rs. 4,00,000/- ☐ Rs. 5,00,000/- ☐ Rs. 10,00,000/-

S.No	Particulars	Insured Person 1	Insured Person 2	Insured Person 3	Insured Person 4	Insured Person 5
24	Voluntary Co-payment	☐ 10% ☐ 20% ☐ 30% ☐ 40% ☐ 50% ☐ No	☐ 10% ☐ 20% ☐ 30% ☐ 40% ☐ 50% ☐ No	☐ 10% ☐ 20% ☐ 30% ☐ 40% ☐ 50% ☐ No	☐ 10% ☐ 20% ☐ 30% ☐ 40% ☐ 50% ☐ No	☐ 10% ☐ 20% ☐ 30% ☐ 40% ☐ 50% ☐ No
25	Sublimits on the Specific Diseases/ Treatments	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
26	Hospital Cash	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
27	Advance Access (Applicable only for 5 years policy term)	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
28	Galaxy Companion (Rider) (UIN: GHIHLIA26047V012526)	☐ No ☐ Silver ☐ Gold ☐ Platinum ☐ Diamond	☐ No ☐ Silver ☐ Gold ☐ Platinum ☐ Diamond	☐ No ☐ Silver ☐ Gold ☐ Platinum ☐ Diamond	☐ No ☐ Silver ☐ Gold ☐ Platinum ☐ Diamond	☐ No ☐ Silver ☐ Gold ☐ Platinum ☐ Diamond
	Health History 1.Is the person proposed for insurance in good health free from physical and mental disease or infirmity? (If this question is not declared, then insured member will be considered in Good Health)	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	1.1.Hypertension/ High Blood pressure History	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	1.2.Diabetes Mellitus / Sugar History	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	1.3.Hyperlipidemia/ Cholesterol History	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	1.4. Any type of Heart disease If yes since when	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	1.5. Asthma / COPD / ILD / Tuberculosis / Covid-19 / any other respiratory conditions if yes, since when	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	1.6. Disease of the kidney/ bladder /Urinary calculus/ Prostate/Hydrocele if yes, since when	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	1.7. Any Disease of the Bones/joints/Ligament/Spine/Disc/any history of Arthritis/ fractures/ osteomyelitis, if yes, since when	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

S.No	Particulars	Insured Person 1	Insured Person 2	Insured Person 3	Insured Person 4	Insured Person 5
	1.8. Any Digestive Diseases/Disease of the Liver/Gallbladder/Pancreas/hernia/piles/fistula/fissure if yes, since when	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	1.9. Cancer/pre-cancerous lesions/ Benign tumour if yes, since when	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	1.10. Any Neurological diseases/mental disorders/stroke/ Alzheimer/parkinsonism/ Seizure disorder/sleep disorder/head injury if yes, since when	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	1.11.Obstetrics and Gynaecology conditions or disorders: a. Any Gynaecological problem for which the female member has consulted a doctor b. Is any female member pregnant, tested positive with a home pregnancy test, or had ectopic pregnancy, or on infertility treatment - if yes, since when	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	1.12. Diseases of any Eye / ENT (Ear ,Nose and Throat) – if yes, since when	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	1.13. Is the person proposed for insurance positive for any Sexually Transmitted Diseases / HIV or AIDS If yes, please mention your CD4 count (Please attach proof) if yes, since when	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

S.No	Particulars	Insured Person 1	Insured Person 2	Insured Person 3	Insured Person 4	Insured Person 5
	1.14. Autoimmune / metabolic / haematological conditions or disorder a. Any autoimmune disease/ intake of steroid/ immunosuppressants b. Thyroid / any Endocrine / Metabolic / obesity c. Any Blood disorder for which treatment has been taken / Blood transfusions	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	1.15. Does the person proposed to be insured suffer from any disability / unable to perform normal activities / bedridden	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	1.16. Has the person applying for insurance had any medical check-ups, treatment or hospitalisation, surgery, or advice for complications during or after childbirth? If yes, please share the details, including the illness, prescribed medicines, and treatment duration	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	1.17. Does the individual have a family history of any disease or any genetic disorder. if yes, since when	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	1.18. Does any insured have any of the following habits? •Smoking •Alcohol •Tobacco in any form	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	1.19. Skin disorder / Allergic disease - if yes, since when	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

S.No	Particulars	Insured Person 1	Insured Person 2	Insured Person 3	Insured Person 4	Insured Person 5
	1.20. Any other problem, please specify	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	1.21. Do you wish to disclose any material information?					
Existing Insurance Coverage with us and/or any other company give details a) Name of the Insurance _____ Company _____ b) Period of Insurance _____ c) Sum Insured _____ d) Policy No. _____						
Claims Details a) Ailment for which claim was made/Year _____ b) Claim Amount Paid _____ Have you ever been declined health insurance coverage due to a diagnosis of a health condition? ☐ Yes ☐ No						
		☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

Submitted the above proposal for **Galaxy Marvel/Galaxy Companion (Rider)** along with payment of Rs. _____ by Cash / Debit Card / Credit Card / NEFT / QR / CC Mandate / UPI / Cheque / DD No. _____ dated _____ drawn on _____.



Received the proposal for **Galaxy Marvel/Galaxy Companion (Rider)** from Mr. / Mrs. / Ms. _____ along with payment of Rs. _____/- by Cash/Debit Card/Credit Card/NEFT/QR/CC Mandate/UPI/Cheque/DD No. _____ dt. _____ drawn on _____.

Date: _____ Place: _____

Name & Code of the authorised person: _____ Signature of the authorised person: _____

Declaration

The primary duty of the proposer is to fill out the proposal form and also to make sure that the proposal contains all the details correctly. If you or any of the insured person(s) have suffered or suffering from any of the diseases which has not been mentioned in the proposal, the claim that may arise will result in a repudiation of the claim/cancellation of the policy. I/we agree that the PAN details and other information provided by me/us in the proposal form may be used by the Company to download/ verify / modify / add my/our KYC documents from the CERSAI* CKYC portal for processing this application. I/We understand that only the acceptable officially valid documents would be relied upon for processing this application. (*Central Registry of Securitization and Asset Reconstruction and security Interest of India) I hereby consent to receiving information from Central KYC Registry through SMS / email on the above registered number/email address.

- 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 from a hospital who/which at anytime 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, Hospitals, TPAs, Insurers etc., which includes sharing of my medical data through ABHA.. I confirm that the payment is made through my card / bank account. I also confirm that the source of funds for premium paid under this policy is legal. I hereby confirm that the features of the product have been understood by me. I hereby authorize Galaxy Health Insurance Company Limited to contact me. It will override my registry on the NCPR.

The company will not be on risk until the proposal has been accepted and full payment of premium has been received.

Place : _____

Date : _____

Name : _____

Signature / Thumb impression of the proposer : _____

WHERE THE PROPOSER IS ILLITERATE OR SIGNS IN A LANGUAGE DIFFERENT FROM THAT OF THE LANGUAGE OF THE PROPOSAL FORM.

I hereby confirm that the details have been explained to the proposer.

Date: _____ Name of the person who explained : _____ Signature of the person who explained : _____

I hereby confirm that every column in this proposal has been filled up by me or read out to me and explained by the person who filled it, wherever I have not filled the columns myself. I have also been informed of the implications of each information furnished in the proposal and that the same will be the basis for acceptance of the contract viz., the issuance of the proposed Policy.

I confirm that the salient features, including the coverage, exclusions and conditions of the Proposed Policy have been explained to me and having understood the same, I subscribed to the Proposal.

In an eventuality of there being any misrepresentation / suppression of any related information, I was informed that the policy so issued will become null & void and will lead to its cancellation in addition to claim if any lodged will be summarily rejected.

Signature / Thumb impression of the proposer : _____

Applicable for Agency / Intermediary

Declaration of the Agent / Intermediary : I / We confirm that the product's suitability has been explained to the proposer. The information furnished in the proposal is true to the best of my knowledge and recommend acceptance of the proposal. (Please Enclose Insurance Agent's Confidential Report, If Any)

Date : _____

Code : _____

Name of the Agent / Specified Person of Corporate Agent / Broker Qualified Person / Insurance Sales Person of the IMF / POSP: _____

Signature of the Agent / Specified Person of Corporate Agent / Broker Qualified Person / Insurance Sales Person of the IMF / POSP : _____

Prohibition of Rebates: Section 41 of Insurance Act 1938

- 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.
- 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.

Beware of spurious phone calls and fictitious/fraudulent offers and never respond to calls/emails/embedded links in SMS/emails asking you to update User id / Password/Credit Card Number/CVV/OTP etc.

Important: Insurance is a contract of the utmost good faith, requiring the insured to answer all of the questions on the proposal form honestly and without omitting any information that is relevant. When submitting the proposal form, kindly reveal all pertinent information. If any important information is omitted from the proposal form, personal statement, declaration, or related papers, or if the proposer or someone acting on his behalf makes any false or erroneous statements, misrepresentations, or omissions, the Policy will be invalid, at the insurer's discretion. Please get in touch with the company's offices or agents if you have any questions about the proposal form.

Note: Please attach any one proof in support of ID, Address (If CKYC number is provided, proof of submission is not mandatory).

Passport, Voter ID, Driving License / Exp Dt., Aadhar Card, NREGA job card (Mahatma Gandhi National Rural Employment Guarantee Act), National Population Register Letter, Any Other Govt. Notified Document, Photo. Politically Exposed Persons (PEPs) are individuals who are or have been entrusted with prominent public functions in a foreign country, example, Heads of State or of Governments, senior politicians, senior government / judicial / military officials, senior executives of state owned corporations, important political party officials, etc., including their family members and close relatives. The company will not be on risk until the proposal has been accepted and full payment of premium has been received.