

SUKSHMA HOSPI-CASH GROUP
(Micro-Insurance Product)
PROPOSAL FORM

IMPORTANT GUIDELINES:

1. Insurance is the contract of utmost good faith requiring of the proposer and 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.
 2. Please answer all questions carefully. Any incomplete, incorrect or partially correct answers may lead to rejection of the proposal and also might lead to cancelation of policy.
 3. It is important to fill all questions, information for fields marked with asterisk [*] is mandatory
 4. Cover shall commence not earlier than the date and the time of acceptance and subsequent to payment of the premium.
 5. This form is to be completed by the Group/ Association/ Institution/ Corporate Body. The Company will not be on risk until the Proposal has been accepted by Company and the full premium paid

WIN NO	
IO No	
App No	
Client Code	
Receipt No	
Payer ID	

Received Date: _____ **Branch Code:** _____ **Branch Name:** _____

Period of Insurance: From: dd/mm/yyyy To dd/mm/yyyy

DETAILS OF THE INSURED/ PROPOSER

1. Name of Proposer*

[illegible]

2. Present Address

[illegible]

3. Permanent Address (If same as above, please tick here) ☐

[illegible]

4. Description of the Proposer's Business

[illegible]

5. Relationship of the insured person(s) with the proposer

[illegible]

6. Please mention the Total number of persons to be covered at the inception of policy :

(Please attach the list of persons to be covered as per the format attached)

7. Please mention the proposed Sum Insured at inception of policy. (in words) _____
8. Please state whether all eligible members of the Group/ Association/ Institution/ Corporate Body are proposed for Insurance? ☐ Yes ☐ No
9. Relationship between Members/Beneficiaries and Group Manager :
Employer–Employee ☐ Non-Employer–Employee ☐
10. Relation of the insured person(s) with the proposer _____
11. True to our Go Green initiative, we will send the digitally signed and authenticated policy document to your e-mail address, as you've mentioned in this proposal, and you may download and save a copy of it. If you still wish for a physical copy, you may tick on this box. ☐ Yes ☐ No
12. **Whether PAN card is provided? if yes, please provide the PAN card no.** _____
(PAN is mandatory where the premium exceeds Rs. One Lakh in any mode.)

13. PRODUCT DETAILS

Option: ☐ 5 days ☐ 10 days ☐ 15 days
☐ 20 days ☐ 25 days

Policy Type: ☐ Individual basis ☐ Family Floater basis (Self, Spouse and maximum up to three dependent children up to 25 yrs)

Daily Cash Amount (Rs): ☐ 100 ☐ 200 ☐ 300 ☐ 400 ☐ 500 ☐ 600 ☐ 700 ☐ 800 ☐ 900 ☐ 1000

Optional Covers:	☐ Convalescence Benefit (can be offered for hospitalization of more than 10 days)
	☐ Pre-existing Disease Cover
	☐ Maternity Benefit Expense Cover with 9 months waiting period
	☐ Maternity Benefit Expense Cover without 9 months waiting period

Deductible opted: ☐ 1 day ☐ 2 days ☐ 3 days

Please note that the coverage will be according to the Final Agreed Quoteslip and the members covered will be as mentioned in Annexure 1.

14. PAYMENT DETAILS:

Premium paid by Cheque No/ NEFT		Date:	DD	MM	YYYY
Bank Name		Amount ((₹):			
Amount (in words)					
GSTIN (If more than one GSTIN, kindly attach an annexure with details)		PAN (if premium is 1 Lac and above.) -			
Please fill up the request for authorization form attached with this proposal form to receive claim/ refund payments, if any and subject to the prescribed law/regulations, directly into your bank account through NEFT. It is necessary where the premium is more than ₹10,000/-.					

DECLARATION

1. I/We hereby declare, on behalf of all persons proposed to be insured, that the statements, answers and/ or particulars given by me/us, above and in Annexure 1 below, are true and complete in all respects to the best of my/our knowledge and that I/We am/are authorized to propose on behalf of these other persons as also for those, who may become part of the insurance cover hereafter.
2. I/We understand that the information provided by me/us 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.
3. I/We further declare that I/We will notify in writing any change occurring in the relationship between the proposer and the persons proposed to be insured after the proposal has been submitted but before communication of the risk acceptance by the company.
4. I/We declare that I/We consent to the company seeking medical information from any doctor or hospital who/which at any time has attended on the persons proposed to be insured or from any past or present employer concerning anything which affects the physical or mental health of the persons proposed to be insured and seeking information from any insurer to whom an application for insurance on the persons proposed to be insured has been made for the purpose of underwriting the proposal and/ or claim settlement.
5. I/We authorize the company to share information pertaining to my/our proposal including the medical records of the persons proposed to be insured for the sole purpose of underwriting the proposal and/or claims settlement and with any Governmental and/or Regulatory authority.
6. I/We, further, declare and warrant that:
 - a. there is no other material/relevant information, that has not been disclosed to GCICL and if any information given in this proposal is found to be untrue, the insurance policy shall be void ab initio and the premium shall be forfeited to GCICL.
 - b. service related information from GCICL, and its service providers, through electronic and telecom modes, including WhatsApp, can be sent to the contact co-ordinates mentioned in this proposal and understand that no unsolicited information will be sent.
 - c. the information/data provided by me/us, through this application, to GCICL and/ or GCICL authorised person/ agency, shall be stored by GCICL, throughout the currency of the proposer's relationship with GCICL, and used for the purposes relating to my/our proposal for insurance cover and/or servicing policies issued in favour of the proposer, whether by GCICL or its authorized partners. I/We also understand that the said storage is necessary for consumption of the services by the persons proposed to be insured and consent, on behalf of all such persons proposed to be insured, to not hold GCICL and/or its authorized partners/ agency/ person liable for legitimate utilization of the submitted information/data.
7. I agree that the information/data, contained in this proposal, shall be processed for purposes related to this proposal and the insurance policy that may be issued hereon. I understand that all such information/data will be handled as per the GCICL Privacy Policy, available at <https://generalicentralinsurance.com/privacy-policy>.
8. **ABHA Declaration (Applicable only if you have shared the ABHA number with Us)** – It is, hereby, declared that the proposer named above stands duly authorized by the proposed insured person to share their respective Ayushman Bharat Health Account number (ABHA nos.) with GCICL. In accordance, the said ABHA nos. are being shared with GCICL for the sole purpose of accessing the records of medical history, which will be used to verify/share relevant information provided herein on confidential basis within its Group and /or third-party agencies in connection with the Claims & policy servicing, for the purpose of facilitating insurance/ reinsurance services and ancillary services.
9. I consent to the fact that GCI may download my/proposer's CKYC record from the Central KYC Records Registry, in relation to the verification of my/proposer's KYC records as part of this proposal. I understand that acceptable officially valid documents shall be relied upon for the said verification of KYC records. I, also, consent to receive information from the Central KYC Registry through SMS/email on the above-mentioned mobile phone number/email address.

It is, also, confirmed that the KYC records available in the CKYC Registry are current and valid, as on the date of this proposal, and can be used by GCI hereafter. In case of any modification, the applicable information will be provided to GCI for updating the CKYC Registry Records.

Date: Proposer's/Group Manager Name:

Place: Proposer's/Group Manager Signature/ Thumb Impression:

For use by Intermediary Only

I, _____, in my capacity as an Insurance Agent/POSP/Specified Person of the Corporate Agent/Authorized Person of the Broker/IMF, declare that I have explained the product features, including its suitability, and the contents of this proposal form, including the nature of the questions and the responses submitted thereto, to the proposer. It has been, further, informed to the proposer that the details provided herein shall form the basis of the contract of insurance between GCICL and the proposer. It has, also, been explained that if any untrue response(s) is/are contained in this proposal form or there has been any non-disclosure of material facts, the policy issued thereon shall, at the option of GCICL, be treated as null and void and the premium amount against the policy may be forfeited by GCICL.

VERNACULAR DECLARATION:

I hereby confirm that the product features and terms of the above product have been explained to the prospect in detail (including product suitability) and to the prospects' complete satisfaction. (In case prospect signs in a language other than English/or is not literate)

*applicable only when proposer has signed in thumb impression and is witnessed by someone other than agent/employee of the company.

I hereby declare that, I have clearly explained the content of this form to the proposer thereafter the proposer has affixed the thumb impression above after fully understanding the content thereof.

Witness Name:	Intermediary / Agent Name
Witness Signature:	Intermediary / Agent Signature
Date and Place	

DECLARATION BY AUTHORIZED REPRESENTATIVE OR PERSON WITH DISABILITY

I, Mr./Ms. _____, authorize Mr./Ms. _____ as my authorized representative to act on my behalf, and for all the persons proposed to be insured, in all matters related to this health insurance proposal, including but not limited to:

- Discussing and obtaining relevant information regarding the health insurance coverage, benefits, features and claims;
- Providing personal and medical information required for completion and processing of this proposal;
- Taking decisions regarding my application/ proposal, claims, servicing requirement and discharge processes, related to the health insurance policy that GCICL may issue;
- Coordinate with designated service providers engaged with/by GCICL for administration of the insurance cover; and
- Signing necessary documents in relation to this health insurance proposal and any other decisions relating to/arising therefrom.

Signature of Proposer:

Name of Authorized Representative :

Relationship with the

Proposer :
Address :

Contact No :

Signature of the Authorized Representative :

Date :

Name of Witness :

Signature of Witness :

Date :

Place :

OR

I, Mr./Ms. _____, have been authorized by Mr./Ms. _____, as their representative to act on their behalf in all matters related to this health insurance proposal, including but not limited to:

- Discussing and obtaining relevant information regarding the health insurance coverage, benefits, features and claims;
- Providing personal and medical information required for completion and processing of this proposal;
- Taking decisions regarding my application/proposal, claims, servicing requirement and discharge processes, related to the health insurance policy that GCICL may issue;
- Coordinate with designated service providers engaged with/by GCICL for administration of the insurance cover; and
- Signing necessary documents in relation to this health insurance proposal and any other decisions relating to/arising therefrom.

Name of Authorized Representative:

Relationship with the

Proposer :

Address

Contact No :

Signature of the Authorized Representative:

Date :

Name of Witness :

Signature of Witness :

Date :

Place :

FOR OFFICE USE ONLY

Intermediary's Name:	Intermediary's Code:
Sales Manager's Name:	Sales Manager's Code:

SECTION 41 OF INSURANCE ACT, 1938-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 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 punishable with fine, which may extend to Ten Lakh Rupees.



Generali Central Insurance Company Limited (Formerly known as Future Generali India Insurance Company Limited) | Registered Office: Unit No. 801 & 802, 8th Floor, Tower C, Embassy 247 Park, LBS Marg, Vikhroli (West), Mumbai – 400083 | IRDAI Regn. No.: 132 | CIN: U66030MH2006PLC165287 | Website: www.generalicentralinsurance.com | Email ID: gcicare@generalicentral.com | Toll-free Phone: 1800 220 233 / 1860 500 3333 / 022 6783 7800
ISO No: GCH/HP/SHG/PFM/001

8	Specify the Percentage (%) of Claim amount payable to each nominee in the event of the policyholder's death. The total percentage of contribution across all the nominee(s) must not exceed 100%				
9	Bank details of the nominee				
9a.	Account No.				
9b.	IFSC/MICR Code				
9c.	Name of the Bank				
9d.	Account Holder Name				
Appointee Details (Required only if the nominee is a minor)					
Sr No	Particulars	Appointee 1	Appointee 2	Appointee 3	Appointee 4
1	Name				
2	Age				
3	Mobile No.				
4	Email ID				
5	Present Address				
6	Permanent Address (If same as above, please tick here) ☐				
7	Relationship with Appointee				
8	Specify the Percentage (%) of Claim amount payable to each nominee in the event of the policyholder's death. The total percentage of contribution across				

	all the nominee(s) must not exceed 100%				
9	Bank details of the Appointee				
9a.	Account No.				
9b.	IFSC/MICR Code				
9c.	Name of the Bank				
9d.	Account Holder Name				

1. Please attach additional sheets, if space not sufficient to complete details.
2. Names of the family members to be covered should be mentioned immediately after the name of each employee/ Member
3. ^^Please provide ABHA numbers (Ayushman Bharat Health Account number) for all the proposed insured. In case the ABHA numbers are not available for any insured Person, Proposer/Group Manager may request the insured Person to create their ABHA numbers by visiting the web link: <https://healthid.ndhm.gov.in/register>

Acknowledgement

Application No: _____

Date: _____

Name of Proposer: _____

We acknowledge with thanks the receipt of your application and amount by cash / cheque _____
of amount of Rs.

_____.

Neither the submission to us of a completed proposal for insurance nor any payment for any policy sought obliges us to agree to issue a policy, which decision is and always shall be in our sole and absolute discretion. If we accept a proposal for insurance, it shall be subject to the policy terms and conditions and we shall have no liability to make any payment if premium is not received by us in full and in time, or is not realised. If we do not accept the proposal, we will inform you and refund any payment received from you without interest within next 30 days.

Signature of the receiver and official seal
