D.I.Y Health
PROPOSAL FORM

IO No/Win No.	**:**
App No.	**:**
Client Code	**:**
Receipt No.	**:**
Payer ID	**:**
SB / CA Account No.	**:**
Journal No. / Bank Name	**:**

GUIDELINES FOR FILLING THIS PROPOSAL FORM

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 complete all sections in capitals and tick the boxes, wherever applicable. It is mandatory to furnish all information for fields marked with an asterisk [*].
3) Failure to disclose facts material to the assessment of the risk or providing misleading information / partial information may lead to rejection of this proposal / cancellation of the policy issued correspondingly.
4) This Proposal Form shall be the basis of the contract for issuance of an insurance policy and shall be signed by the proposer.
5) We are under no obligation to accept any proposal for insurance. Our liability will commence only when this proposal is accepted by Us (subject to the terms and conditions of the policy) and the premium is received.

Receive Date:	**Branch Name:**	**Branch Code:**

I. DETAILS OF PROPOSER

Proposer Name* :☐ Mr. ☐ Mrs. ☐Ms. ☐Mx.

Date of Birth* : D D M M Y Y Y Y Age (in years) :

Marital Status* : ☐ Married ☐ Single ☐ Widow / Widower ☐ Divorcee ☐ Live-in relation

Nationality* ☐ Indian ☐ NRI ☐ Others (please specify) :

Gender* : ☐ Male ☐ Female ☐ Third Gender E-mail ID* :

Occupation : ☐ Self Employed ☐ Salaried ☐ Homemaker ☐ Retired ☐ Others (please specify)

PAN:			(Mandatory where the premium exceeds Rs. 50,000/- in cash and where premium exceeds Rs. One Lakh in any mode)		
Permanent Address* :	Landmark	:		City / Town	:
	District	:		Pin Code*	:
	Telephone No.*	:		Mobile No.*	:
Present Address* (If same as above, please tick here) ☐ :	Landmark	:		City / Town	:
	District	:		Pin Code*	:
	Telephone No.*	:		Mobile No.*	:

Are you an existing Generali Central Customer?* : ☐ Yes ☐ No

If Yes, please provide, Existing Policy No. : Customer ID :

II. DETAILS OF PERSONS PROPOSED TO BE INSURED*

#Definition of Family - Individual Sum Insured Policy - Self, Spouse/Live-in partner, Children (up to 25 years of age), Parents, Siblings, Daughter-in-law, Son-in-law, Parents-in-law, Grandparents and Grandchildren. Floater Sum Insured for INR 4 and 5 lac Policy - Self, Spouse/Live-in partner, Children (up to 25 years of age). Floater Sum Insured for INR 6 lac and above Policy - Self, Spouse/Live-in partner, Children (up to 25 years of age), parents and parents-in-law.

S.No.	Name	Gender (Male/Female/Third Gender)	Date of Birth (DD/MM/YYYY)	ABHA No.^^	Relationship with Proposer	Height (Cm)	Weight (Kg)	Occupation
1	Primary Insured				Self			
2								
3								
4								

5								
6								
7								
8								
9								
10								
11								
12								
13								
14								
15								

III. Please attach age proof document for each person proposed to be insured. The documents mentioned below will be considered for proof of age.
^^Please provide ABHA number (Ayushman Bharat Health Account number) for all the proposed Insured Persons. In case the ABHA number is not available for any Insured Person, you may request to create an ABHA number by visiting the web link: https://healthid.ndhm.gov.in/register

Passport, PAN Card, Driving License, School/ College leaving certificate, Letter from recognized public authority.

Policy Period * : ☐ 1 Year ☐ 2 Years ☐ 3 Years

Proposed Policy Period* : From : D D M M Y Y To : D D M M Y Y

Cover Type* : ☐ Individual ☐ Family Floater

***COVERAGE DETAILS**

*The Sum Insured and optional benefits will be at policy level for Individual / Floater cover types.
Voluntary Co-pay and Deductible can be opted for on mutually exclusive basis. ** If you choose for optional cover, you must choose at least three of the available optional covers.
*** If you have chosen the sum insured for a particular plan, then you are eligible to choose the sub-limit, waiting period, and optional benefits for that plan only.
$ For Porting and Migration policies, only two years' waiting period for pre-existing diseases and specified disease/procedure is available as an option.

Details of Benefits	Cover		***Mini	***Medi	***Max
*Sum Insured	Base cover		☐ ₹4,00,000	☐ ₹ 6,00,000	☐ ₹11,00,000
			☐ ₹ 5,00,000	☐ ₹ 7,00,000	☐ ₹12,00,000
				☐ ₹ 8,00,000	☐ ₹13,00,000
				☐ ₹9,00,000	☐ ₹14,00,000

				☐ ₹10,00,000	☐ ₹15,00,000
Pre-Hospitalization	Base cover		☐ 30 days ☐ 60 days ☐ 90 Days		
Post Hospitalization	Base cover		☐ 60 days ☐ 90 days ☐ 120 Days		
$ Pre-Existing Waiting Period	Base cover		☐ 1 year ☐ 2 years ☐ 3 years		
$ Specified diseases - Waiting Period	Base cover		☐ 1 year ☐ 2 years		
Room Rent	Base cover		☐ 1 % of sum insured	☐ 1 % of sum insured	☐ 1 % of sum insured
			☐ No capping	☐ No capping	☐ No capping
ICU	Base cover		2 times of the Room Rent selected / "No Capping" will be applicable, in case Room Rent is selected with "No Capping"		
OPD Cover	Base cover		☐₹2,000	☐₹3,000	☐₹5,000
			☐₹3,000	☐₹5,000	☐₹7,500
					☐₹10,000
LASIK Surgery	Base cover		☐₹30,000	☐₹50,000	☐₹75,000
			☐₹50,000	☐₹75,000	☐₹10,0000
*** Optional Benefits**					
Maternity Benefit (Pre & Post natal expenses covered within maternity limits) – Portability and Migration are not applicable	☐ Yes ☐ No		☐ Normal ₹20,000 Caesarean ₹30,000	☐ Normal ₹30,000 ₹20,000 Caesarean	☐ Normal ₹20,000 Caesarean ₹30,000
			☐ Normal ₹30,000 ,Caesarean ₹50,000	☐ Normal ₹50,000 ₹30,000 Caesarean	☐ Normal ₹30,000 Caesarean ₹50,000
				☐ Normal ₹75,000 ₹50,000 Caesarean	☐ Normal ₹50,000 Caesarean ₹75,000
					☐ Normal ₹75,000

					Caesarean ₹100,000
Pre Natal Expenses			30 days	60 days	90 days
Post Natal Expenses			45 days	45 days	45 days
Road Ambulance	☐ Yes ☐ No		☐₹ 1,000	☐₹ 1,500	☐₹ 2,000
			☐₹ 1,500	☐₹ 2,000	☐₹ 3,000
			☐₹ 2,000	☐₹ 3,000	☐₹ 5,000
Emergency Air Ambulance	☐ Yes ☐ No		₹1,00,000	₹3,00,000	₹5,00,000
Daily Hospital Cash	☐ Yes ☐ No		☐₹250	☐₹500	☐₹ 1,500
			☐₹500	☐₹ 1,000	☐₹ 2,000
			☐₹ 1,000	☐₹ 1,500	
				☐₹ 2,000	
Convalescence Benefit	☐ Yes ☐ No		☐₹ 5,000		
			☐ ₹10,000		
Accompanying Person (For patient less than 12 years)	☐ Yes ☐ No		☐₹250	☐₹500	☐₹1,500
			☐₹500	☐₹750	☐₹2,000
				☐₹1,000	
Accidental Death (Primary Member)	☐ Yes ☐ No		☐₹1,00,000	☐₹ 2,00,000	☐₹ 3,00,000
			☐₹2,00,000	☐₹ 3,00,000	☐₹ 4,00,000
				☐₹ 4,00,000	☐₹ 5,00,000
Accidental Death (Spouse of Primary Member)	☐ Yes ☐ No		☐₹1,00,000	☐₹ 2,00,000	☐₹ 3,00,000
			☐₹2,00,000	☐₹ 3,00,000	☐₹ 4,00,000
				☐₹ 4,00,000	☐₹ 5,00,000
Critical Illness Booster	☐ Yes ☐ No		☐ 1.5 times of the sum insured.		
			☐ 2 times of the sum insured.		

Cumulative Bonus Booster	☐ Yes ☐ No		Max. up to 500 % of Base Sum Insured.					
Accident Booster	☐ Yes ☐ No		☐ 1.5 times of the sum insured. ☐ 2 times of the sum insured.					
Non-Medical & Consumables Expenses Cover	☐ Yes ☐ No		Cover for non-medical and consumable expenses (15% of admissible claim amount)					
Home Health Care	☐ Yes ☐ No		Covered up to 20% of the Sum Insured.					
Alternative Treatments	☐ Yes ☐ No		Up to the Sum Insured.					
#Voluntary Co-Payment	☐ Yes ☐ No		☐ 10 % ☐ 20 % ☐ 30 %					
#Voluntary Deductible Option	☐ Yes ☐ No		Deductible Discount		Deductible	Discount	Deductible	Discount
			☐ ₹ 10,000	8%	☐ ₹ 10,000	8%	☐ ₹ 50,000	15%
			☐ ₹ 25,000	15%	☐ ₹ 25,000	15%	☐ ₹ 75,000	20%
			☐ ₹ 50,000	20%	☐ ₹ 50,000	20%	☐ ₹ 100,000	25%

IV. NOMINEE DETAILS

In case the Policyholder (Presently, proposer) dies, payments due under the policy that may be issued shall be payable to the credit of the nominees identified through this proposal. Nominee(s) for the proposal shall, preferably, be an immediate relative of the Proposer. Vide insurable interest of the proposer in the other persons proposed to be insured, the proposer is construed as nominee for such other persons, unless differently advised.

Sr No	Particulars	Nominee 1	Nominee 2	Nominee 3	Nominee 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 the Proposer				
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				

V. MEDICAL AND HEALTH INFORMATION							
	A	B	C	D	E	F	G
Sr. No.	Are you in good health and free from physical and mental disease or infirmity or medical complaints or deformity?	Do you regularly consume tobacco / alcohol or smoke - (please specify – yes/ no. If yes please mention – quantity / day, number of years since consuming/ smoking)?	Does any person to be insured suffer or has suffered in the past from any of the following? Disorder of the heart including ischemic heart disease / rheumatic heart disease, or circulatory system, chest pain, high blood pressure, stroke, asthma, any respiratory condition, cancer or tumour / lump of any kind, diabetes, hepatitis, disorder of urinary tract or kidneys, blood disorder, any mental or psychiatric conditions, any disease of brain or nervous system, fits (epilepsy), slipped disc, backache, any congenital / birth defects / disease, AIDS or tested positive for HIV, or any other disease – yes / no. If “yes”, Indicate in the table given below.	Name of disease / illness / injury being suffered from, in the past or at present. Any other diseases or ailments not mentioned? If "yes”, give details in the table given below.	Disease / illness / injury / suffering since when / when first treated (Applicable to question V-C and D both). If applicable, please mention details. If not Applicable, please mention “no” in the table given below.	Treatment / Medication received / receiving. If applicable, please mention details. If not Applicable, please mention “no” in the table given below.	Are you fully cured? (Yes /No) - applicable only if any of the points from “c" to “f" is “Yes”.
Insured 1	Yes/no	Yes/no	Yes/no	Yes/no			
Insured 2	Yes/no	Yes/no	Yes/no	Yes/no			
Insured 3	Yes/no	Yes/no	Yes/no	Yes/no			
Insured 4	Yes/no	Yes/no	Yes/no	Yes/no			
Insured 5	Yes/no	Yes/no	Yes/no	Yes/no			

Insured 6	Yes/no	Yes/no	Yes/no	Yes/no			
Insured 7	Yes/no	Yes/no	Yes/no	Yes/no			
Insured 8	Yes/no	Yes/no	Yes/no	Yes/no			
Insured 9	Yes/no	Yes/no	Yes/no	Yes/no			
Insured 10	Yes/no	Yes/no	Yes/no	Yes/no			
Insured 11	Yes/no	Yes/no	Yes/no	Yes/no			
Insured 12	Yes/no	Yes/no	Yes/no	Yes/no			
Insured 13	Yes/no	Yes/no	Yes/no	Yes/no			
Insured 14	Yes/no	Yes/no	Yes/no	Yes/no			
Insured 15	Yes/no	Yes/no	Yes/no	Yes/no			

VI. CONCURRENT/PREVIOUS INSURANCE POLICY DETAILS

Are you having existing Health Policy of Generali Central or are you insured under any other Health Insurance Policy? YES ☐ NO ☐
(If YES, Please provide details in below table)

Name of Insured Person	Policy Number	Name of Insurer	Policy Period		Sum Insured (in INR)	Claim filed (if Yes, give details)	Product Name
			From	To			
			DD/MM/YY	DD/MM/YY			
			DD/MM/YY	DD/MM/YY			
			DD/MM/YY	DD/MM/YY			

			DD/MM/YY	DD/MM/YY			
			DD/MM/YY	DD/MM/YY			
			DD/MM/YY	DD/MM/YY			
			DD/MM/YY	DD/MM/YY			
			DD/MM/YY	DD/MM/YY			
			DD/MM/YY	DD/MM/YY			
			DD/MM/YY	DD/MM/YY			

Are you applying for porting / migration? ☐ Yes ☐ No (If Yes, portability / migration form to be completed and attached)
For Porting and Migration policies, only two years' waiting period for pre –existing diseases and waiting period of specified disease/procedure is available as an option.

VII. PREMIUM PAYMENT AND BANK DETAILS*

Instalment Details: If you want to opt for premium payment in instalment option, please tick the required details from the below options ☐ YES ☐ NO
(below fields are mandatory, if instalment option is opted for)

Mandate Type	Bank Name	Mode of payment	Bank branch	Account Number	IFSC	MICR Code	Account Type	Frequency
								☐ Monthly ☐ Quarterly ☐ Half Yearly ☐ Yearly

*Link will be sent to the registered mobile number mentioned in this Proposal Form for activating E-mandate/E-NACH. If the same is not activated, the subsequent instalment will not be auto debited and risk will not be covered. *The updated list of eligible Banks for E-mandate/E-NACH is available under National Payments Corporation of India (NPCI) website* https://www.npci.org.in/

Payment Details :

Payment Option : Cheque ☐ Demand Draft ☐ Fund Transfer ☐ Pay Order ☐ Debit Card ☐ Credit Card ☐ Cash ☐

Premium Amount	: ₹ _____	Amount (in words):	_____
Account Holder Name	: _____		
Instrument Number	: _____	Instrument Date	: _____
Instrument Amount	:	Bank Name	:
GSTIN	: _____	(If more than one GSTIN, kindly attach an annexure with details)	

Please fill up the request for authorisation form attached with this Proposal Form to receive Claim / Refund Payments, if any, directly into your bank account through NEFT. It is necessary, where the premium is more than ₹ 10,000/-.

VIII. ELECTRONIC INSURANCE ACCOUNT DETAILS OF PROPOSER

(Email ID is mandatory)

Do you have an EIA : ☐ Yes ☐ No

If Yes, please quote the EIA number : <<_____>>

If No, do you wish to apply for EIA : ☐ Yes ☐ No

If applied, please mention your preferred Insurance Repository : <<_____>>

Email ID (Registered with Insurance Repository) : <<_____>>

Your Policy will be credited in your EIA account and your address details as mentioned in the EIA shall override the address provided in this proposal for insurance. We request you to inform the Insurance Repository of any changes in the details immediately.

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 ☐

IX.	DECLARATION
1)	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 authorised to propose on behalf of these other persons.
2)	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.
3)	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.
4)	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.
5)	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.
6)	I further declare that: ☐ 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. ☐ I agree to receive Service related information from GCICL and its service providers, through electronic and telecom modes, including WhatsApp, and further understand that no unsolicited information will be sent to me. ☐ The information/ data provided by me through this Proposal Form, to GCICL and / or GCICL authorized personnel / agency shall be stored by GCICL, throughout the currency of my relationship with GCICL and used for the purpose relating to my proposal for insurance cover and or servicing policies issued in my favour, whether by GCICL or its authorized partners. I also understand that the said storage is necessary for my consumption of the services and consent to not hold GCICL and / or its authorized partners / agency / personnel liable for legal utilization of the submitted information / data.
7)	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 GCICL reserves 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.
8)	I hereby confirm that the premium payment has been made by _____, who is having an insurable interest in my policy under this application form. In case of any refund, please process the same in the below mentioned proposer's bank account.
9)	I am (please tick all that are applicable) ☐ HNI ☐ NRI ☐ Politically Exposed Person ☐ Jeweller ☐ NGO ☐ Film Actor ☐ Producer ☐ Others
10)	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

11) **ABHA Declaration (Applicable only if you have shared the ABHA number with Us)** - I, hereby declare that I am voluntarily sharing Ayushma Bharat Health Account number (ABHA No) for the proposed
Insured Persons, with Generali Central Insurance Company Limited., for the sole purpose of accessing my 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, for the purpose of facilitating insurance/ reinsurance services and ancillary services

12) 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.

13) **"Bima – ASBA Declaration (Please tick the box if you want to utilize the Bima-ASBA facility)**

☐ I hereby accord my consent to authorise Generali Central Insurance Company Limited 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"

Optional Declaration:

I hereby give my consent to the Company to use my personal information for quality and data analysis purpose which may be carried out by an empaneled third party vendors ☐ Yes / ☐ No

*Note: I hereby acknowledge that I have read and understood the contents of the prospectus and have been explained the features, contents and terms of the * Prospectus/ Product Wordings by the Intermediary/Agent to my satisfaction (*to download a copy of the Prospectus or Policy Wordings and for further details about the product, please visit our website* https://generalicentralinsurance.com*)*

Date: _____ Place: _____ Name of Proposer: _____ Signature / Thumb Impression of Proposer: _____

X. A INTERMEDIARY DECLARATION

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. I have further informed the proposer that the details provided herein shall form the basis of the contract of insurance between GCICL and the proposer. I have also 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 to GCICL.

X B VERNACULAR DECLARATION

 # applicable only when proposer has signed in thumb impression and is witnessed by someone other than agent/ employee of GCICL

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

Name of Witness : _____ Signature of Witness : _____

Date : _____ Place : _____ Signature of Agent / Intermediary : _____

POSP Name: _____ POSP Code: _____ POSP PAN No.: _____

X. C 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:

a) Discussing and obtaining relevant information regarding the health insurance coverage, benefits, features and claims;
b) Providing personal and medical information required for completion and processing of this proposal;
c) Taking decisions regarding my application/ proposal, claims, servicing requirement and discharge processes, related to the health insurance policy that GCICL may issue;
d) Coordinate with designated service providers engaged with/by GCICL for administration of the insurance cover; and
e) 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:

a) Discussing and obtaining relevant information regarding the health insurance coverage, benefits, features and claims;
b) Providing personal and medical information required for completion and processing of this proposal;
c) Taking decisions regarding my application/proposal, claims, servicing requirement and discharge processes, related to the health insurance policy that GCICL may issue;
d) Coordinate with designated service providers engaged with/by GCICL for administration of the insurance cover; and
e) 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	:

Prohibition of Rebates: Section 41 of the Insurance Act, 1938 (and amendments thereof)
1) No person shall allow or offer to allow, either directly or indirectly, as an inducement to any person to take out 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 liable for penalty which may extend to ten lakh rupees.

FOR OFFICE USE ONLY							
Intermediary Name	:			Intermediary Code	:		
Sales Manager Name	:			Sales Manager Code	:		