PROPOSAL FORM - CORONA RAKSHAK POLICY, UNIVERSAL SOMPO GENERAL INSURANCE COMPANY



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

Instructions to fill the form

- Please answer all the questions in BLOCK letters tick in relevant boxes. Please note all details are mandatory and if any particular question is not applicable pls. state "N/A".
- This proposal shall form the basis of the insurance policy to be issued by us. Hence you are requested to disclose all facts pertaining to all the persons proposed for insurance with us, without omitting any particulars. Non-compliance of the above may result in the avoidance of the Policy & we shall have no liability to make any payment under the Policy
- The acceptance of this proposal shall be subject to the terms and conditions of this policy

If more space is require	ed to answer a quest	tion, please atta	ch additional s For Office U						
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		nward No.	Receipt	No. F	eceipt Date:				
Intermediary Name, Conta Code & Email	act No, In	termediary Sales I Contact No		Source C	ode/POS UID Aad	dhar No./PAN P	olicy Issuir	ng Office Addr	ess & Code
PROPOSER'S DETAILS									
Title: Mr. / Miss / Mrs. / M	/s / others (if others	nlesse specify							
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Name:			Middle Name						
					_	ast Name			
Gender: Male Fema			Birth:			ality:			
Marital Status: Single		Others							
Correspondence Addre									
District:									
City/Town			Pin Co	de: L_					
Mobile/ WhatsApp No:									
Permanent Address:									
District:									
City/Town	State:	1	Pin Co	de:					
Contact No.		Email							
Occupation: Salaried	Self Occupied				•	s			
ID Proof Type: PAN	Passport Dri	ving License	Voter's Ca	_					
ID Proof No.				Annual Ind	ome :	GSTIN No:			
CKYC No.:									
Confirmation for Issuan withInsur		Policy: E Insur	ance account	no		I would lik	e to ope	n E-Insurano	e account
POLICY DETAILS	ance Repository.								
Proposed Period of Insu	wansa 2 1/2 Manth	4 1/4 M	lonths 🗆 🧐	9 ½ Months					
Policy Start Date:	rance: 3 72 Month		cy End Date:						
Type of Cover: Individual		Polic	cy End Date:						
Sum Insured (Rs.50, 00		ultiples of 50	000) •						
Sum msurea (Ks.50, 00	to 2.5 lakiis iii iii	ultiples of 30,	,000). ——						
PROPOSED INSURED	INFORMATION								
Sr. Name	Gender	Date	Pre-existing	Relatio	nship Do	you have any othe	r policy	Height	Weight
No.	(M/F/TG*		illness	wit	h co	vering novel Coro	navirus	(in cms)	(in kg)
		Birth	if any,	Propo	ser	issued by the comp If yes please ment			
						the policy number			
						Product name			
3								+	
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			ID (Ayushma						Third Gender
Insured I	Insured 2		Insured 3	Inst	ired 4	Insured 5		Insured	16
NOMINEE INFORMAT	•				Т.		<u> </u>	V 1 **	*.1
Sr. Nomine	e iname		nship with with Insured	Nominee DOB		intee Name if inee is minor	"	Relationship Proposer	
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2									
3									
4									

UIN: UNIHLIP21104V012021

Name of the Premium Payer:		
Relationship to Proposer:		
Mode of Payment: Cash Cheque Debit/Credit Card	DD Other	
Instrument Bank Details	Instrument Date	Amount in INR
Sources of funds: Salary Business Other please specify Debit Authorization for Current & Future Renewal Premiums		
I hereby authorize bank to debit my account number	with the ban	k for Rs.
towards first premium for availing the said Universal Sompo Health In	surance Cover.	
I hereby request and authorize the bank to debit my account num	ber	on the yearly due dates with the
applicable renewal premium.		
AML GUIDELINES		
I. I/We hereby confirm that all premiums have/will be paid from bona fire		fill be paid out of proceeds of crime related
to any of the offence listed in prevention of Money Laundering Act, 20. 2. I understand that the company has the right to call for documents to a		
3. The insurance company has the right to cancel the insurance contract		by any competent court of law under any
of the statues, directly or indirectly governing the prevention of mone	ey laundering in India.	
 Nationality:		
PAN Card Number		
7. Any other		
DECLARATION		
I. I hereby declare, on my behalf and on behalf of all persons proposed		
me are true and complete in all respects to the best of my knowledge 2. I understand that the information provided by me will form the basis		
the insurance Company and that the Policy will come into force only		
3. I further declare that I will notify in writing any change occurring in the		ne life to be insured/proposer after the
proposal has been submitted but before communication of the risk ac 4. I declare that I consent to the company seeking medical information f		nich at any time has attended on the person
to be insured/proposer or from any past or present employer concer	ning anything which affects the phys	sical or mental health of the person to be
insured/proposer and seeking information from any insurer to whom		person to be insured /proposer has been
made for the purpose of underwriting the proposal and/or claim settle 5. I authorize the company to share information pertaining to my propo		the insured/proposer for the sole purpose
of underwriting the proposal and/or claims settlement and with any G		
Date:	Signature of the Proposer	
	Signature of the Froposer	
Place:	Name of the Proposer	
Place:	Name of the Proposer	
Place : VERNACULAR DECLARATION	Name of the Proposer	
Place: VERNACULAR DECLARATION Certification in case of the proposer has signed in vernacular (to be witness)	Name of the Proposerses by someone other than Agent/E	imployee of the company)
Place: VERNACULAR DECLARATION Certification in case of the proposer has signed in vernacular (to be witness Name of the Proposer:	Name of the Proposerses by someone other than Agent/E	imployee of the company)
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UIN: UNIHLIP21104V012021

Version: USGI150_H003

IRDAI Reg No: 134

PAYMENT DETAIL