

Application No:

Agent Code:

**Guidelines For Completion Of The Form (to Be Filled By Proposer) :-**

1.This is an application for insurance and issuance of this does not amount to acceptance of proposal by us. Commencement of risk under this proposal is subject to acceptance of the risk by us and receipt of premium. 2.The information declared by you in this form is the basis for issuance of the policy. Please answer all questions carefully and in BLOCK letter.

**For Office Use Only**

Intermediary Name:	Intermediary Contact No.:	Intermediary Reference Code:
Intermediary Email:	Intermediary Sales Person's Name:	
Intermediary Sales Person's Contact:	Intermediary Sales Person's Code:	Source Code:
POS UID Aadhar No./PAN:	Policy Issuing Office Code	
Policy Issuing Office Address:		

**1. PROPOSERS DETAILS**

<b>Name of the Proposer</b>	
<b>Address</b>	
<b>Landmark</b>	
<b>City</b>	<b>Pin code</b> <b>State</b>
<b>Gender</b>	Male <input type="checkbox"/> Female <input type="checkbox"/> Third Gender <input type="checkbox"/> <b>Date of Birth</b> DD/MM/YYYY
<b>E Mail ID</b>	<b>Mobile No.</b>
<b>ID Type</b>	Aadhar Card* <input type="checkbox"/> Driving License <input type="checkbox"/> Passport <input type="checkbox"/> Pan Card <input type="checkbox"/> <b>ID Number</b>
<b>CKYC No.</b>	
<b>Nationality</b>	<b>Monthly Salary Paid to Helper *</b>
<b>Do you have eIA account? If Yes, Account details</b>	<b>I would like to apply for eIA with:</b> <input type="checkbox"/> Karvy <input type="checkbox"/> CAMS <input type="checkbox"/> NSDL <input type="checkbox"/> CSDL

**2. POLICY DETAILS**

<b>Policy Type</b>	New <input type="checkbox"/> Renewal <input type="checkbox"/> Migration <input type="checkbox"/>	<b>Policy Tenure</b>	1 year <input type="checkbox"/> 2 year <input type="checkbox"/> 3 year <input type="checkbox"/>
<b>Policy Tenure From</b>	DD/MM/YYYY	<b>Policy Tenure To</b>	DD/MM/YYYY

**3. PREMIUM DETAILS ( Including GST )**

Section 1: Health											
Sum Insured (in Lacs)	<input type="checkbox"/> 2.5	<input type="checkbox"/> 3	<input type="checkbox"/> 3.5	<input type="checkbox"/> 4	<input type="checkbox"/> 4.5	<input type="checkbox"/> 5	<input type="checkbox"/> 5.5	<input type="checkbox"/> 6	<input type="checkbox"/> 6.5	<input type="checkbox"/> 7	<input type="checkbox"/> 7.5
<b>Age</b>											
18-35 <input type="checkbox"/>	2183	2537	2738	2938	3080	3221	3280	3339	3398	3457	3575
36-55 <input type="checkbox"/>	3979	4626	4991	5345	5617	5888	5994	6101	6207	6313	6525
>55 <input type="checkbox"/>	6726	7823	8449	9062	9534	10006	10172	10349	10526	10703	11057

Section 2: Personal Accident											
Sum Insured (in Lacs)	<input type="checkbox"/> 2.5	<input type="checkbox"/> 3	<input type="checkbox"/> 3.5	<input type="checkbox"/> 4	<input type="checkbox"/> 4.5	<input type="checkbox"/> 5	<input type="checkbox"/> 5.5	<input type="checkbox"/> 6	<input type="checkbox"/> 6.5	<input type="checkbox"/> 7	<input type="checkbox"/> 7.5
<b>Premium</b>	251	301	352	401	452	502	552	602	653	702	753

\*Maximum Sum Insured offered is 10 times of Annual Income all PA policies cumulatively.

**4. DETAILS OF THE PERSON TO BE COVERED**

Insured Name (First, middle, Last)	Date of birth (DD/MM/YYYY)	Age	Gender (M/F/T)	ABHA ID	Relationship with proposer	Height (cm)	Weight (kg)	Occupation / Duty

**5. NOMINEE DETAILS**

The nominee must be an immediate relative of the Insured Person.

Sr No	Name of Insured	Name of Nominee	Date of Birth	Age	Relationship	Gender(M/F/TG)	Address of the Nominee

\*If the Nominee is Minor, Name and relationship with minor.

Name of the Appointee	Relationship	Date of Birth	Age	Gender(M/F/TG)	Address of the Appointee

**6. MEDICAL AND LIFESTYLE INFORMATION**

a) Please accurately answer the following questions about person proposed to be insured.

If the answer to any of these questions is YES, please provide the complete details in the table for additional medical information.

**Important:** You must answer these questions truthfully.

Sl. No	Details	Insured 1
1.	Proposed Insured Member suffering from any illness or disease at present or in the recent past? If yes, please give details	Yes <input type="checkbox"/> No <input type="checkbox"/> Details : _____
2.	Person proposed to be insured ever suffered from or taken treatment, or hospitalized for or have been recommended to take investigations/ medication/surgery or undergone a surgery for any of the following – Diabetes; Hypertension; Ulcer/Cyst/Cancer; Cardiac Disorder; Kidney or Urinary Tract Disorder; Disorder of muscle/bone/joint; Respiratory disorder; Digestive tract or gastrointestinal disorder; Nervous System disorder; Mental Illness or disorder, HIV or AIDS. If yes, please give details	Yes <input type="checkbox"/> No <input type="checkbox"/> Details : _____

b) Does any person proposed to be insured consume any of the following?

	Insured	Substance
Alcohol	Yes <input type="checkbox"/> No <input type="checkbox"/>	30ml <input type="checkbox"/> More than 30 ml <input type="checkbox"/>
	No. of Years	Quantity**
Smoking	Yes <input type="checkbox"/> No <input type="checkbox"/>	5 Cigarettes <input type="checkbox"/> More than 5 Cigarettes <input type="checkbox"/>
	No. of Years	Quantity(No./Day)
Any other substance like Tobacco/Guthka/Pan/ Pan Masala, etc	Yes <input type="checkbox"/> No <input type="checkbox"/>	1 pouch/ 10 grams <input type="checkbox"/> More than 1 pouch/ 10 grams <input type="checkbox"/>
	No. of Years	Quantity(Pouch/Day)

Narcotics	Yes <input type="checkbox"/> No <input type="checkbox"/>	
	No. of Years	Quantity(Pouch/Day)

\*\*Beer – No. of Pints per week, Wine & Spirit – ml/week)

If any of these habits has been in the past please mention the year of stopping it and the reason for doing the same\_habit\_\_\_\_\_

## 7. ADDITIONAL MEDICAL INFORMATION

If you have answered YES to any of the questions in section 4, please give full details here. If you need more space please use extra sheets.

If you are unsure whether any details are relevant, please include them

Substance	Insured 1
Name of illness/injury suffering from or suffered in the past	
Date of first diagnosis (Month & Year)	
Treatment/medication received/receiving	
Treatment outcome (fully cured/partially cured/ ongoing, etc)	

## 8. GENERAL INFORMATION

I. Existing Insurance Details : If the proposed Insured has any other Health / Personal Accident Policy, please share details:

Sr No	Policy No	Name of insured person	Insurer	Period of Insurance		SI & Cumulative bonus /Rs	Claims details if any
				From (DD/MM/YYYY)	To (DD/MM/YYYY)		
1							
2							
3							
4							

## 9. PAYMENT & BANK ACCOUNT DETAILS

. Premium Details:

Premium Amount: Rs. \_\_\_\_\_ in words \_\_\_\_\_

Cash :

Cheque/NEFT/DD Payment Option: Cheque/NEFT/DD Number : \_\_\_\_\_ Cheque/NEFT/DD Date: \_\_\_\_\_

Bank Name : \_\_\_\_\_

Card Payment Option :

Mode of Payment : Debit Card  Credit Card  Date of Expiry \_\_\_\_\_

Visa/Master Card No : \_\_\_\_\_ Name of the Bank: \_\_\_\_\_

Please make a A/C Payee Cheque/DD/Pay Order in favour of 'Universal Sampo General Insurance Company Limited' only

## 10. DECLARATION

I, \_\_\_\_\_ affirm the following regarding the helper, \_\_\_\_\_, employed as at my residence/place.

I hereby declare, to the best of my knowledge, that our house help/helper is in sound health, without any known pre-existing medical conditions, and is not currently undergoing any medical treatment or therapy, as required for this health insurance proposal.

I/We further declare that I/we will notify in writing any change occurring in the occupation or employment 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/We authorize the company to share information pertaining to my proposal including the medical records for the sole purpose of proposal underwriting and/or claims settlement and with any Governmental and/or Regulatory authority."

I/We declare and consent to the company seeking medical information from any doctor or from a hospital who at any time has attended on the life to be insured/proposer or from any past or present employer concerning anything which affects the physical or mental health of the life to be assured/proposer and seeking information from any insurance company to which an application for insurance on the life to be assured/proposer has been made for the purpose of underwriting the proposal and/or claim settlement.

\*I / We/ US – Proposer & Insured

"I/We hereby declare, on my behalf and on behalf of person 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/We am/are authorized to propose on behalf of these other person.

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 insurance company and that the policy will come into force only after full receipt of the premium chargeable.

I consent and authorize Universal Sampo General Insurance Company Limited ("Company") and its representatives to collect, use, share and disclose information provided by Us, as per the privacy policy of the Company. Company or its representatives are also hereby authorized to contact me (including overriding my registry on NCPR/NDNC and/or under any extant TRAI regulations) and / or notify about the services being rendered by the Company.

Date : \_\_\_\_\_ Signature of the Proposer: \_\_\_\_\_ Signature of the Insured: \_\_\_\_\_

Place : \_\_\_\_\_ Name of Proposer : \_\_\_\_\_ Name of the Insured : \_\_\_\_\_

## 11. VERNACULAR DECLARATION

I hereby declare that I have fully explained the contents of the Proposal Form and all other documents incidental to availing the health insurance from Universal Sampo General Insurance Company Limited to the Proposer in the language understood by him/her and that the Proposer has affixed the thumb impression above after fully understanding the contents thereof.

The same have been fully understood by him/her and the replies have been recorded as per the information provided by the Proposer and the replies have been read out to fully understood and confirmed by the Proposer.

Date : \_\_\_\_\_ Signature of the Proposer: \_\_\_\_\_ Signature of the Insured: \_\_\_\_\_

Place : \_\_\_\_\_ Name of Proposer : \_\_\_\_\_ Name of the Insured : \_\_\_\_\_

## 12. AGENT DECLARATION

I, \_\_\_\_\_ (Full Name) in my capacity as an Insurance Advisor/ Specified Person of the Corporate Agent/Authorised employee of the Broker/Relationship Officer, do hereby declare that I have explained all the contents of this Proposal Form, including the nature of the questions contained in this Proposal Form to the Proposer including statement(s), information and response(s) submitted by him/her in this Proposal Form to questions contained herein or any details sought herein will form the basis of the Contract of Insurance between the Company and the Proposer, if this Proposal is accepted by the Company for issuance of the Policy. I further confirm that I have explained the product features, terms and conditions to the prospect and the product opted is suitable to the need of the customer.

I have further explained that if any untrue statement(s)/ information/response(s) is/are contained in this Proposal Form/including addendum(s), affidavits, statements, submissions, furnished/to be furnished, the Company shall have the right to vary the benefits which may be payable and further more if there has been a non-disclosure of any material fact, the policy issued to his/her favour pursuant to this Proposal may be treated by the Company as null and void and all premiums paid under the Policy may be forfeited to the company.

License No. (Advisor/Corporate

Agent/Broker/Relationship Officer): \_\_\_\_\_

Date: \_\_\_\_\_ Place: \_\_\_\_\_ Signature of Agent \_\_\_\_\_

## 13. INSURANCE ACT 1938, SECTION 41 - PROHIBITION OF REBATES

1. 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 or 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 prospectus or tables of the Insurer.

2. Any person making default in complying with the provisions of this section shall be punishable with fine, which may extend to Ten Lakhs rupees.

## 14. CHECK LIST

Please check the following documents are attached along with the proposal form

ID Proof : Passport/ PAN Card/ Voter ID/ Driving License/ Letter from a recognized public authority

Proof of residence: Telephone Bill/ Bank Account Statement/ Letter from any recognized public authority/Electricity Bill/ Ration Card

Age Proof: Proof of Age

Renewal Notice with claim details

Certification of previous insurer for previous claim details

Photocopies of all previous policies and endorsements

## Universal Sampo General Insurance Co. Ltd.

Unit No 601/602, A Wing, 6th Floor, Reliable Tech Park, Cloud City Campus, Gut No 31, Mouje Elthan, Thane Belapur Road, Airoli, Navi Mumbai - 400708

Toll Free No : 1800 200 4030 / 1800 22 4030, for Senior Citizen : 1800 267 4030 I Tel No.: 022 41690888/41690999

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@universalsampo.com

Insurance is the subject matter of solicitation. For more details on risk factors, terms and conditions please read Policy Documents carefully before concluding a sale. IRDAI or its officials do not involve in activities like sale of any kind of insurance or financial products nor invest premiums. IRDAI does not announce any bonus. Those receiving such phone calls are requested to lodge a police complaint along with details of phone call and number.

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