Saksham Bima, USGI

PROPOSAL FORM

GUIDELINES FOR COMPLETION OF THE FORM

- This policy is specially designed for Persons with Disability and Persons with HIV/AIDS.
  - **a.** Persons with Disability shall be covered if 40% disability is certified by the competent authority as per the Disability Act 2016.
  - **b.** Persons who are HIV/ AIDS positive Individuals with CD4 count above 500 shall be covered.
- Please answer all questions correctly and completely.
- Information for fields marked with asterisk (*) are mandatory.
- Only Indian Nationals can be covered under this policy.
- Note: The Coverage proposed for insurance is not covered until the proposal is accepted and premium is paid and the same is realized by Name of the Insurance Company.

Intermediary Details

Intermediary Name	
Intermediary Code	
Intermediary Contact Details	

Proposer Details*:

Name		
Communication Address		
	City:	State:
	Pin-code:	Landmark:
Contact Details	Phone	Email
Profession:	Salaried ☐ Self-Employed ☐ Other ☐ Details: _____	
Occupation and Nature of Business/ Work:		
PAN No./ form 60/61		
AADHAAR No.		
CKYC No.		
Date of Birth		
Gender	Male ☐ Female ☐ Other ☐	

Coverage Details:

Policy Type	Individual Basis
Policy period	1 year
Period of Insurance	From *DD /MM / YYYY* to *DD /MM / YYYY*
Sum Insured	400000 ☐ 500000 ☐
Coverage opted:	Pre-existing HIV/AIDS ☐ Pre-existing Disability ☐ Pre-existing HIV/AIDS and Disability ☐

Details of Persons to be Insured:

Sr No	Name of the Insured	Nationality	Date of Birth	Age	Gender	Height	Weight	Occupation	Marital Status	Relation with Proposer
1					M/F/O					

ABHA ID (Ayushman Bharat Health Account)					
Insured 1	**Insured 2**	**Insured 3**	**Insured 4**	**Insured 5**	**Insured 6**

Nominee Details:

Name	Date of Birth	Age	Relationship with Insured

Where Nominee is a minor, give the details of Appointee

Name of the Appointee	Date of Birth	Age	Relationship with Insured

Previous/Existing Health Details of Insured:

Do you suffer from HIV/AIDS?	Yes/No	If Yes, please enclose a recent certificate of your current CD4 count (within past 30 days)
Current CD 4 count		
Has your CD4 Count gone below 500 in the past 4 years?	Yes/ No . If yes when and How many times _____	
History of Tuberculosis/ Herpes Infection?	Yes/No	
Are you suffering from any mental/psychiatric health issues?	Yes/No	If yes, Confirm the ailment_____
Do you suffer from any disability as per the listed conditions mentioned below:	Yes/ No	If Yes, please enclose Disability certificate mentioning percentage of disability wherever applicable.

1. Blindness ☐	*2. Muscular Dystrophy ☐*
3. Low vision ☐	*4. Chronic Neurological conditions ☐*
5. Leprosy Cured persons ☐	*6. Specific Learning Disabilities ☐*
7. Hearing Impairment (deaf and hard of hearing) ☐	*8. Multiple Sclerosis ☐*
9. Locomotor Disability ☐	*10. Speech and Language disability ☐*
11. Dwarfism ☐	*12. Thalassemia ☐*
13. Intellectual Disability ☐	*14. Haemophilia ☐*
15. Mental Illness ☐	*16. Sickle Cell disease ☐*
17. Autism spectrum disorder ☐	*18. Multiple Disabilities including deaf/ blindness ☐*
19. Cerebral Palsy ☐	*20. Acid Attack victim ☐*
21. Parkinson's disease ☐	

- Do you suffer from any pre-existing illness other than Disability or HIV AIDS mentioned above? Yes ☐ No ☐
  If Yes, please specify details and the no of years you are suffering: _____
- Are you or proposed Insured suffer from any other comorbid condition/s? Yes ☐ No ☐
  If yes, Confirm the ailment_____
- Are you or proposed 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 Systemdisorder?

Yes ☐ No ☐

- Are you or proposed Insured able to do your daily - routine activities like eating, bathing, cleaning & clothing by our own?

  Yes ☐ No ☐

- Are you or proposed Insured dependent on others for your daily routine activity like eating, bathing, cleaning & clothing?
  Yes ☐ No ☐

- Are you or proposed Insured consume any of the following-

Substance		Insured 1	Insured 2	Insured 3	Insured 4
Alcohol		Yes No	Yes No	Yes No	Yes No
	Quantity**				
	No. of Years				
Smoking		Yes No	Yes No	Yes No	Yes No
	Quantity(No./Day)				
	No. of Years				
Any other substance like Tobacco/Guthka/Pan/ Pan Masala, etc		Yes No	Yes No	Yes No	Yes No
	Quantity(Pouch/Day)				
	No. of Years				
Narcotics		Yes No	Yes No	Yes No	Yes No
	Quantity(Pouch/Day)				
	No. of Years				

Previous/Existing Health Insurance details

Policy No. / Application No.	Insurer Name	Period of Insurance (from – to)	Sum Insured	Claims lodged during the preceding years

Electronic Insurance Account Details Section:

I want _____related information in – Physical Format- Yes/No e-Format (electronic) as & when applicable- Yes/No
Choose your Insurance Repository (For those selecting e-Format) (a) NSDL Data Management Ltd. (b) CDSL Insurance Repository Ltd (c) Karvy Insurance Repository Ltd. (d) CAMS Repository Services Ltd
I have e Insurance Account & the No. is _____
My CKYC No. (Central Know Your Customer registry number) is (If available) _____

Premium Payment Details:

Name of Premium payer:	
Premium Payment Frequency:	Monthly / Quarterly / Half Yearly
Premium Amount: _____	Cheque ☐ DD ☐ Debit Card / Credit Card ☐

Instrument Type:	Cash/ Cheque/ Debit Card/ Credit Card/ Others: Please Specify:
Date (DD/MM/YYYY):	Cheque no.
Bank Name:	Bank Account Number:
IFSC Code:	Branch Name:

Bank Account Details For Process Of Refund:
Cheque will be issued in the name of the Proposer only.

In case of cancellation of policy, if premium was paid through credit card the refund amount would be credited to Credit Card account directly or refund will be paid through cheque. Please provide the following bank details and a copy of Cancelled Cheque if you opt for direct credit of refund/ claim into your bank account:(Cancelled Cheque should be of the same bank account in which the refund needs to be credited directly.

Name of Account holder	
Cheque No	
Bank Name	
Branch Name	
Cheque Date	
Cheque Amount for ₹	
Name as in Bank Account	
Bank Account No	
IFSC Code	
MICR Code	

Note: The Proposer agrees and undertakes to intimate in writing to Universal Sompo General Insurance Co Ltd about any change in bank account details.

If ECS is selected, please submit the standing instruction form available at our branches.

Place: Signature of proposer:
Date: DD/MM/YYYY

AML Guidelines

I/ We hereby confirm that all premiums have been/ will be paid from bonafide sources and no premiums have been/ will be paid out of proceeds of crime related to any of the offence listed in Prevention of Money Laundering Act 2002. I/We understand that the Company has the right to call for documents to establish source of funds. The insurance Company has the right to cancel the insurance contract in case I am/ have been found guilty by any competent court of law under any statues, directly or indirectly governing the prevention of money laundering in India.

Agent's 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 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.

Date: ---------
Place: ---------

Signature of Agent: ----------
Licence No.----------

Declaration & Warranty on behalf of all Persons Proposed to be Insured

i. I/We hereby declare on my behalf and on behalf of all persons proposed to be insured that the above statements 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 persons.
ii. I understand that the information provided by me will form the basis of insurance policy, is subject to the Board approved under writing policy of the Insurance company and that the policy will come into force only after full receipt to the premium chargeable.
iii. I/We further declare that I/We 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.
iv. I/We declare and further consent to the company. Seeking medical information from any 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 and mental health of the life to be assured/proposer and seeking information from any insurance company to which an application or insurance on the life to be assured/proposer has been made for the purpose of underwriting the proposal and /or claim settlement.
v. 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.
vi. I/We aware of premium loading, (if any declared above) for habit's & diseases as declared / mention by me/ us above.
vii. I/ We hereby agree to keep record of KYC details of all the individual members covered under the group insurance, and ensure to provide the details of beneficiaries to the Company as and when required.

Vernacular Declaration

** Applicable where the Proposer is illiterate or is suffering from a disability due to which writing is restricted or where the Proposer has signed in vernacular language. (Note: The below must be witnessed by someone other than the Advisor/Employee of the Company).

I/We certify that the product applied for by me/us and the contents of the Proposal Form have been clearly explained to me/us and I/we have fully understood them. I/We further certify that the replies in the Proposal Form have been recorded as per the information provided by me/us. I, (Full name of the witness) _____ (Relation with the Proposer/Primary insured) _____adult and inhabitant of (city) _____and residing at _____do hereby certify that I have read out and explained the contents of the Proposal Form and all other documents incidental to availing the insurance policy from Universal Sompo General Insurance Co Ltd., to the Proposer/Primary Insured and he/she/they have understood the same. I/we declare that whatever I/we have stated herein above is true and correct to the best of knowledge and belief.

Date: DD MM YYYY Place:

Signature of the Witness Signature/Thumb impression of the Proposer/Primary Insured

SECTION 41 OF INSURANCE ACT, 1938

As per Section 41 of the Insurance Act 1938, as amended, the practice of rebating is prohibited, as follows:

(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 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

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

Product Name – Saksham Bima, USGI I Version Number – USGI240_H002 I URN Number – USGIHP075