SUPREME HEALTHCARE POLICY
Proposal Form
Registered and Corporate Office : Office No. 103, 1st Floor, Ackruti Star, MIDC Central Road, Andheri (East), Mumbai 400 093,Maharashtra.Email : contactus@universalsompo.com Contact Number – 1800 22 4030, 1800 200 4030

FOR OFFICE USE ONLY

PROPOSER DETAILS

Name : Mr. / Ms. / M/S
|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|

(First Name) (Middle Name) (Last Name)

Date of Birth / Incorporation (in case Proposer is an entity) : |__|__|/|__|__|/|__|__|__|__|(DD/MM/YYYY)

Correspondence Address :
|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|

|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|

Locality :|__|__|__|__|__|__|__|__|__|__|__|__| City :|__|__|__|__|__|__|__|__|__|__|__| __|__|

PIN Code :|__|__|__|__|__|__| State : |__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|

Landmark : |__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|

Permanent Address : If same as above, please tick here |__|

|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|

|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|

Locality : |__|__|__|__|__|__|__|__|__|__|__|__| City :|__|__|__|__|__|__|__|__|__|__|__|

PIN code : |__|__|__|__|__|__| State : |__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|

Contact Details : Landline (R) :|__|__|__|__|__|__|__|__|__|__| (O) : |__|__|__|__|__|__|__|__|__|__|

(STD Code) (STD Code)

Mobile No : |__|__|__|__|__|__|__|__|__|__| Alternate No : |__|__|__|__|__|__|__|__|__|__|

*The registered mobile number will be enrolled for Whats App notifications related to your Health Insurance Policy

E-mail ID : |__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|

Gender : |__| (M / F/Others (O))

Mother's Name : |__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|

P.A.N. : |__|__|__|__|__|__|__|__|__|__|

Form 60 (only in case customer does not have PAN no) : Yes |__| No |__|

Aadhar Number (last 4 digits): |_x_|_x_|_x_|_x_|_x_|_x_|_x_|_x_|_x_|_x_|__|__|__|__|

(By signing the Proposal form I give my consent for using my Aadhar No. for Aadhar Authentication)

Please share the following for authentication purpose:

Proof of Identity (POI) ((☑ Tick whichever is applicable)
PAN|__|Aadhar|__|Passport|__|Driving License|__| Voter ID Card |__| Letter from a recognized public authority or public servant verifying the identity and residence of the Proposer |__|
Proof of Address (POA) ((☑ Tick whichever is applicable)
Electricity bill (not older than 3 months)|__|Aadhar|__|Passport|__|Ration Card|__| Driving License|__| Telephone Bill (not older than 3 months)|__| Bank Account Statement (not older than 3 months)|__|Letter from a recognized public authority or public servant verifying the identity and residence of the Proposer|__|

Nationality : Indian |__| Other than Indian |__|

Marital Status : Single |__| Married |__| Divorced |__|Widow(er) |__|Separated|__|

Would you like to opt for Electronic Policy Issuance through an e-Insurance Account (eIA) of an Insurance Repository? Yes |__| No |__|

If you have an eIA, please provide following details

a) Name of Insurance Repository: |__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|
b) eIA No: |__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|
c) Name as appearing in eIA: |__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|

If you do not have an eIA, would you like to open an account? Yes |__| No |__|

If Yes, choose any one Insurance Repository:

|__| CAMSRep – CAMS Insurance Repository & Services |__| NDML – NSDL Data Management Limited

|__| KARVY Insurance Repository Limited |__| CIRL – Central Insurance Repository Limited

Help us preserve the environment by opting to receive policy related information in soft copy/via email only- Yes |__| No |__|

Nominee details:

Name: |__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|

Date of Birth : |__|__|/|__|__|/|__|__|__|__|(DD/MM/YYYY)

Relationship with Proposer :|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|

Appointee name (Only where the Nominee is of Age 18 years or less) :

Mr. / Ms. |__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|

In event of the death of the Proposer any payment due under the Policy shall become payable to the Nominee proposed in this Proposal Form. The receipt of the proceeds by the Nominee would be sufficient discharge of the Company. The Nominee for all the other person(s) proposed to be insured shall be the Proposer himself.

POLICY DETAILS

Sum Insured (in Rs.): |__|__|__|__|__|__|__|__| **Tenure:** |__| 1Year|__| 2Years|__| 3Years

Cover Type : Individual |__|Floater |__| **Details of Optional Benefit(s) as per Annexure – I**
Are you applying for portability? Yes |__| No |__| (If yes, please fill in the separate Portability Form)

Details of the Proposed to be Insured including Proposer

Particulars		Insured 1	Insured 2	Insured 3	Insured 4	Insured 5	Insured 6
Name	First Name						
	Last Name						
Date of Birth (DD/MM/YYYY)							
Gender (M / F/Others (O))		M |__| F |__|O |__|	M |__| F |__|O |__|	M |__| F |__|O |__|	M |__| F |__|O |__|	M |__| F |__|O |__|	M |__| F |__|O |__|
Relationship with Proposer							
Marital Status							
Aadhaar Number /PAN(optional)							
Nominee (Relationship with Insured)							
City of Residence							
Annual Income (in Rs.)		|_____|	|_____|	|_____|	|_____|	|_____|	|_____|
Height (in centimeters)							
Weight (in kilograms)							
Have you ever been entrusted with prominent public functions, for example, Heads of State or of Government, senior politicians, senior government, judicial or military officials, senior executives of state owned		Yes |__| No |__|	Yes |__| No |__|	Yes |__| No |__|	Yes |__| No |__|	Yes |__| No |__|	Yes |__| No |__|

corporations or important political party officials.						

Medical / Lifestyle related Information

Particulars	Insured 1	Insured 2	Insured 3	Insured 4	Insured 5	Insured 6
Has any proposed insured currently or in past Diagnosed/Suffered/Treated/Taken Medication for any of the following conditions: **If yes, please provide details in the additional information section below**:						
1. Cancer, tumor, polyp or cyst	Yes |__| No |__| Since_____	Yes |__| No |__| Since_____	Yes |__| No |__| Since_____	Yes |__| No |__| Since_____	Yes |__| No |__| Since_____	Yes |__| No |__| Since_____
2. Any heart disease or disorder, chest pain or discomfort, irregular heartbeats, palpitations or heart murmur	Yes |__| No |__| Since_____	Yes |__| No |__| Since_____	Yes |__| No |__| Since_____	Yes |__| No |__| Since_____	Yes |__| No |__| Since_____	Yes |__| No |__| Since_____
3. Hypertension / High Blood Pressure(BP)/ High Cholesterol/Any other Lipid disorders	Yes |__| No |__| Since_____	Yes |__| No |__| Since_____	Yes |__| No |__| Since_____	Yes |__| No |__| Since_____	Yes |__| No |__| Since_____	Yes |__| No |__| Since_____
4. Asthma / Tuberculosis (TB) / COPD/ Pleural effusion / Bronchitis / Emphysema or any other disease of Lungs, Pleura and airway or Respiratory disease ?	Yes |__| No |__| Since_____	Yes |__| No |__| Since_____	Yes |__| No |__| Since_____	Yes |__| No |__| Since_____	Yes |__| No |__| Since_____	Yes |__| No |__| Since_____
5. Thyroid disease/ Cushing's disease/ Parathyroid Disease/ Addison's disease / Pituitary tumor/ disease or any other disorder of Endocrine system ?	Yes |__| No |__|	Yes |__| No |__|	Yes |__| No |__|	Yes |__| No |__|	Yes |__| No |__|	Yes |__| No |__|

6. Diabetes Mellitus / High Blood Sugar / Diabetes on Insulin or medication	Since_____	Since_____	Since_____	Since_____	Since_____	Since_____
7. Motor Neuron Disease/ Muscular dystrophies/ Myasthenia Gravis/ Demyelinating disease or any other disease of Neuromuscular system (muscles and/or nervous system)	Yes |__| No |__| Since_____	Yes |__| No |__| Since_____	Yes |__| No |__| Since_____	Yes |__| No |__| Since_____	Yes |__| No |__| Since_____	Yes |__| No |__| Since_____
8. Stroke/ Paralysis/ Transient Ischemic Attack/ Multiple Sclerosis/ Epilepsy/ Mental-Psychiatric illness/ Parkinsonism/ Alzheimer's/ Depression / Dementia or any other disease of Brain and Nervous System?	Yes |__| No |__| Since_____	Yes |__| No |__| Since_____	Yes |__| No |__| Since_____	Yes |__| No |__| Since_____	Yes |__| No |__| Since_____	Yes |__| No |__| Since_____
9. Cirrhosis / Hepatitis / Wilson's disease / Pancreatitis / Liver disease / Crohn's disease / Ulcerative Colitis //Inflammatory Bowel Diseases/ Piles or any other disease of Mouth, Esophagus, Liver, Gall bladder, Stomach or Intestines or any other part of Digestive System?	Yes |__| No |__| Since_____	Yes |__| No |__| Since_____	Yes |__| No |__| Since_____	Yes |__| No |__| Since_____	Yes |__| No |__| Since_____	Yes |__| No |__| Since_____
10. Kidney Stones/ Renal Failure/ Dialysis/ Chronic Kidney Disease/ Prostate Disease or any other disease of Kidney, Urinary Tract or reproductive organs?	Yes |__| No |__| Since_____	Yes |__| No |__| Since_____	Yes |__| No |__| Since_____	Yes |__| No |__| Since_____	Yes |__| No |__| Since_____	Yes |__| No |__| Since_____
11. HIV/SLE/ Rheumatoid Arthiritis / Scleroderma / Sarcoidosis/ Psoriasis/ bleeding or clotting disorders or any other diseases of Blood, Bone marrow/ Immunity or Skin.	Yes |__| No |__| Since_____	Yes |__| No |__| Since_____	Yes |__| No |__| Since_____	Yes |__| No |__| Since_____	Yes |__| No |__| Since_____	Yes |__| No |__| Since_____
12. Disease or disorder of eye, ear, nose or throat (except any sight related problems	Yes |__| No |__|	Yes |__| No |__|	Yes |__| No |__|	Yes |__| No |__|	Yes |__| No |__|	Yes |__| No |__|

corrected by prescription lenses)?	Since_____	Since_____	Since_____	Since_____	Since_____	Since_____
13. Disease of the musculoskeletal system /Orthopedic disorders/Degeneration , Fracture or dislocation of bones or joints/ avascular necrosis of joints or any other disorder related to it?	Yes |__| No |__| Since_____	Yes |__| No |__| Since_____	Yes |__| No |__| Since_____	Yes |__| No |__| Since_____	Yes |__| No |__| Since_____	Yes |__| No |__| Since_____
14. Smoke, consume alcohol, or chew tobacco, ghutka or paan or use any recreational drugs? If 'Yes' then please indicate the following:	Yes |__| No |__| Since_____	Yes |__| No |__| Since_____	Yes |__| No |__| Since_____	Yes |__| No |__| Since_____	Yes |__| No |__| Since_____	Yes |__| No |__| Since_____
• Hard Liquor (No. of Pegs in 30 ml per week)	____	____	____	____	____	____
• Beer(Bottles/ml per week)	____	____	____	____	____	____
• Wine(Glasses/ml per week)	____	____	____	____	____	____
• Smoking (no. of Sticks per day)	____	____	____	____	____	____
• Gutka /Pan Masala/Chewing Tobacco(Sachets/Grams per day)	____	____	____	____	____	____
15. Any other disease / health adversity / injury/ condition / treatment not mentioned above?	Yes |__| No |__| Since_____	Yes |__| No |__| Since_____	Yes |__| No |__| Since_____	Yes |__| No |__| Since_____	Yes |__| No |__| Since_____	Yes |__| No |__| Since_____
16. Has any of the Proposed to be Insured been hospitalized/recommended to take investigations/medication or has been under any prolonged treatment/ undergone surgery for any illness/injury other than for childbirth/minor injuries?	Yes |__| No |__| Since_____ Yes |__|	Yes |__| No |__| Since_____ Yes |__|	Yes |__| No |__| Since_____ Yes |__|	Yes |__| No |__| Since_____ Yes |__|	Yes |__| No |__| Since_____ Yes |__|	Yes |__| No |__| Since_____ Yes |__|

17. Has any of the Proposed to be Insured have been suffering/suffered from Covid-19 disease? If yes, confirm if any complications arise due to covid-19	No |__| Since_____ Yes |__| No |__| Since_____	No |__| Since_____ Yes |__| No |__| Since_____	No |__| Since_____ Yes |__| No |__| Since_____	No |__| Since_____ Yes |__| No |__| Since_____	No |__| Since_____ Yes |__| No |__| Since_____	No |__| Since_____ Yes |__| No |__| Since_____

Note: The Company shall reject Your proposal and refund the premium amount (after deducting cost of medical tests, if any) in case of incompleteness or any discrepancy highlighted or any other reason.

ADDITIONAL INFORMATION (IF YOUR ANSWER IS 'YES' TO ANY OF THE ABOVE QUESTIONS OR THE PROPOSED TO BE INSURED ARE SUFFERING FROM ANY OTHER PRE EXISITNG DISEASE WHICH IS NOT MENTIONED IN THE ABOVE LIST)

_____

_____

_____

_____

DETAILS OF PREVIOUS OR EXISTING HEALTH INSURANCE

Please fill the following details with respect to health insurance proposals / policies with the Company or any other insurance companies

Particulars	Insured 1	Insured 2	Insured 3	Insured 4	Insured 5	Insured 6
Have any of the person(s) to be insured ever filed a claim with their current/ previous insurer? If Yes, please provide details on a separate sheet	Yes |__| No |__|	Yes |__| No |__|	Yes |__| No |__|	Yes |__| No |__|	Yes |__| No |__|	Yes |__| No |__|
Has any of your proposal(s) for Health insurance been declined, cancelled, charged a higher premium or issued with special condition(s)?	Yes |__| No |__|	Yes |__| No |__|	Yes |__| No |__|	Yes |__| No |__|	Yes |__| No |__|	Yes |__| No |__|
Is any of the person(s) proposed for insurance covered under any other health insurance policy with the Company or any other Company without break?	Yes |__| No |__| Since___ (DD/MM/	Yes |__| No |__| Since___ (DD/MM/	Yes |__| No |__| Since___ (DD/MM/	Yes |__| No |__| Since___ (DD/MM/	Yes |__| No |__| Since___ (DD/MM/	Yes |__| No |__| Since___ (DD/MM/

	YYYY)	YYYY)	YYYY)	YYYY)	YYYY)	YYYY)

Coverages

I. **Base Cover**
II. **Add On Covers:**

Insured	1	2	3	4	5	6
Deductible amount– on an aggregate basis per Policy Year (in Rs.)	__ (in years)	__ (in years)	__ (in years)	__ (in years)	__ (in years)	__ (in years)
Co-payment (in %)						
Optional Benefit : Smart Select (Yes/No)						
Optional Benefit: Room Rent Modification (Yes/No)						
Optional Benefit: PED wait period modification (Yes/No)						
If opted for Optional Benefit PED wait period modification then waiting period opted (1 Year/ 2 Years/ 3 Years)						
Optional Benefit : Named Ailment Wait Period Modification (Yes/No)						
Optional Benefit : Instant Cover (Yes/No)						
Optional Benefit : New Born cover (Yes/No)						
Optional Benefit : Plus Benefit (Yes/No)						
Optional Benefit : Cumulative Bonus Super (Yes/No)						
Optional Benefit : Annual Health Check-up (Yes/No)						
Optional Benefit : Be-fit Benefit (Yes/No)						
Optional Benefit : Wellness Benefit (Yes/No)						
Optional Benefit : Air Ambulance Cover (Yes/No)						
Optional Benefit : Women care (Yes/No)						
Optional Benefit : Mental Health wellbeing (Yes/No)						
Optional Benefit : Claim Shield (Yes/No)						
Optional Benefit : Inflation Shield (Yes/No)						
Optional Benefit: Additional Sum Insured for Defined Critical Illnesses (Yes/No)						
Optional Benefit: Home Modification (Yes/No)						
Optional Benefit: Nursing Care (Yes/No)						

Declaration

a. 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 authorized to propose on behalf of these other persons.
b. 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.
c. 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.

d. 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.

e. 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.

f. I/We authorize the Company to share / verify the information provided by me/us pertaining to my proposal with rating agencies, third parties or services providers for the purpose of underwriting the proposal, issuance, servicing and claims settlement of the policy, thereafter.

g. ☐ I hereby consent to and authorize Universal Sompo General Insurance Company Limited ("Company") and its representatives to collect, use, share and disclose information provided by me, 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.

h. ☐ I would like to protect my environment and would like to help save paper by authorizing Universal Sompo General Insurance Co Ltd to send all my Policy and service-related communication to the email id as mentioned in this form

Place : |__|__|__|__|__|__|__|__|

Date : |__|__|/|__|__|/|__|__|__|__|(DD/MM/YYYY)

Signature of the Proposer : ____

(On behalf of all the Proposed to be Insured under the Policy)

Premium Payment

Payment By : Cash / Cheque / Demand Draft / Card /ECS (NACH)/Reward Points/Wallet/Any other mode (Strike out whichever is not applicable)

Premium payment mode: Single|__|Monthly|__|Quarterly|__|Half-yearly|__|

(☑ Tick whichever is applicable)

Premium Amount (INR): |__|__|__|__|__|__|__|__|

Cheque / Demand Draft No. / Authorization ID : |__|__|__|__|__|__|

Date : |__|__|__|__|__|__|__|__| Payment Amount (INR) : |__|__|__|__|__|__|__|__|

Bank Name : |__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|

For Premium computation, Zone shall be considered as per Correspondence address

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

In case of payment through Cheque / Demand Draft, the instrument should be drawn in favour of 'Universal Sompo General Insurance Company Limited'

NEFT Details for Claims & Refund Purpose

Account No. : |__|__|__|__|__|__|__|__|__|__|__|__|__|
Bank Name : |__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|
Bank Branch Name : |__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|
IFSC Code : |__|__|__|__|__|__|__|__|__|__|__|__|
Name of the Account Holder : |__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|

Note : Please submit copy of cancelled cheque along with Proposal Form

I declare that the information given above is true and correct. I hereby authorize Universal Sompo General Insurance Company Limited to directly credit payout/refund, if any, to the above mentioned account and I shall not hold Universal Sompo General Insurance Company Limited responsible for non-credit/non-payment of payout or refund, if any, due to any reason including but not limited to incorrect/incomplete information. Universal Sompo General Insurance Company Limited reserves right to use any alternative payout option such as cheque/demand draft in spite of providing above information.

Date : |__|__|/|__|__|/|__|__|__|__|(DD/MM/YYYY)

Signature of the Proposer : ____

Agent Declaration

I, (Full Name)____ in my capacity as an Insurance Advisor/ Specified Person of the Corporate Agent/Authorized 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.

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.**

Version Number : **URN Number:**

UNIVERSAL SOMPO 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 I Tel No.: 022 41690888/41690999
Email : contactus@universalsompo.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 compliant along with details of phone call and number.

UIN: UNIHLIP25030V012425