

**PROPOSAL FORM -
SURVA VIDYARTHI BIMA YOJANA**



Registered and Corporate Office : Office No. 103, 1st Floor, Ackruti Star, MIDC Central Road, Andheri (East), Mumbai - 400 093, Maharashtra.
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Intermediary Name, Contact No, Code & Email	Intermediary Sales Persons Name, Contact No & Code	Source Code/POS UID Aadhar No./PAN	Policy Issuing Office Address & Code

Instruction to the School/ Educational Institution

This proposal should be answered after detailed enquiry of all persons to be covered

- This proposal must be completed, signed and dated by a Principal or Director.
- You must answer all the questions in this form. If a question is not applicable, state "N/A". If more space is required to answer a question, please attach additional sheets.
- If you have any questions concerning this proposal, please contact your insurance advisor or the Company to discuss.

1) Name of the School Educational Institution :

2) Address :

City : Pin Code :

Distance of the premises (in Kilometres) from the City :

3) Phone Number :

4) Email :

5) Identification Proof Number :

PAN Card Details :

Registration Number :

CKYC No.:

Copy of MOU/AOA :

Any other, please specify : _____

6) Type of School (check all boxes that apply:

- | | | |
|---|---|--|
| <input type="checkbox"/> Kindergarten | <input type="checkbox"/> Whole-day primary School | <input type="checkbox"/> Bi-sessional Primary School |
| <input type="checkbox"/> Secondary School | <input type="checkbox"/> College/ University | <input type="checkbox"/> Special School |
| <input type="checkbox"/> International School | <input type="checkbox"/> Boarding School | <input type="checkbox"/> Vocational/ Technical |
| <input type="checkbox"/> Public School | <input type="checkbox"/> Private for Profit | <input type="checkbox"/> Private Not for Profit |

Others (Explain): _____

7) Enrollment and Employment information:

Enrollment	Current Year	Prior Year	2 nd Prior Year
Full Time Students			
Part Time Students			
Special Education			
Students with disability			
Other			
Total			

8) Do you wish to cover Students with disablement as indicated above? Y N

Premium: _____

Employment	Current Year	Prior Year	2 nd Prior Year
Full Time Professors/Teachers			
Part Time Professors/Teachers			
Non-Certified Professors/Teachers			
Administrative Personell, including Official, Principals, administrators etc			
Other Professional Staff			
Social Workers			
Volunteers			
Total			

9) Details of Policy Holder:

Name of the School Educational Institution :

Mail Address of School / Educational Institutes:

Details of Insured Member's (Students) :- Section A

Sl. No.	Name of Students	Gender (M / F / TG*)	DOB of Student	Name of Parents	Nominee	Nominee Relationship to the Insured Member	Sum Insured per Students
Total No.	Total Sum Insured of the Section A-Covering Students						

(as per annexure attached)

* Third Gender

Details of Insured Parents covered if opted as per Section A

Name	Date of Birth	Gender (M / F / TG*)	Occupation	Mailing Address	Contact Details	Sum Insured Per Parent	Nominee	Relationship Nominee with Insured	
(as per annexure attached)									
Total No.					Total Sum Insured of the Section A-Covering Parents				

* Third Gender

ABHA ID (Ayushman Bharat Health Account)

Insured 1	Insured 2	Insured 3	Insured 4	Insured 5	Insured 6

Note: For each students please attached the desired details separately as attachment

- Please provide break - up of discipline of Studies: _____
- What are the fees per semester of the discipline? : _____
- Does the discipline opted by them require manual work? If answer to above question is "Yes", please provide details on a separate sheet.
- Indicate percentage of the proposed Students falling under below mentioned age brackets:

3-5 Years Old	
5-9 Years Old	
10-12 Years Old	
12-14 Years Old	
15-19 Years Old	
19-25 Years Old	
25 and above	

- Are the Students as a mandate as per your policy required compulsorily to stay within premises during the semester? Y N
If "No" what is the average time (in Hours) the Students spend on the premises in a day? Hours
- Claims experience for a minimum period of three years

Month/Year	Insurer	Premium Paid	Incurred Claims (reserved+outstanding)

- Do the Students engage in
 - International Student Exchange? Y N
 - School Trips? Y N
 - Ballooning or Polo or Sports of similar nature? Y N
 - Winter Sports, Skating or Ice Hockey? Y N
- Have you ever proposed for Accident / Medical Insurance for the Students? Y N
If so, please give name and address of each Company and amount of Insurance.
- Has any Company
 - Declined to issue a policy to you? Y N
 - Declined to continue your Insurance? Y N
 - Not invited the renewal of your Policy? Y N
 - Imposed any restriction or special conditions? Y N
 If so, please give name and address of each Company in respect of a, b, c, d above
- Is this Insurance to be additional to any other Accidental Policy or Student Medical Scheme? Y N

- If so give particulars of all other policies
- Name and address of Company:
 - Number of Students covered under the Policy:
 - Benefits under the Policy:
 - Sum Insured:
 - Policy Number:

- Do any of the Students suffer from any kind of disability/ infirmity? Y N
If yes, please provide complete details.

DETAILS OF THE RISK

- Policy Period: (DDMMYYYY)
Policy Start Date : Policy End Date:
- Capital Sum Insured for the Students :
- Capital Sum Insured for the Parents :
- Please mention the coverages/ endorsements you want to opt for under the Policy

(i) Section - A- Benefits

Section A	Section A-	Personal Accident	Y/N	Sum Insured	Premium
BENEFITS	Benefit 1	Death of the Parent			
	Benefit 2	Permanent Total Disablement of the Parent			
	Benefit 3	Permanent Partial Disablement of the Parent			
	Benefit 4	Death of the Student			
	Benefit 5	Permanent Total Disablement of the Students			
	Benefit 6	Permanent Partial Disablement of the Students			

(ii) Extensions under section A

EXTENSIONS (SECTION A)	Extensions		Y/N	Sum Insured	Premium	Default Deductible
	Extension 1	Loss of Personal Belongings (Specified Articles)				5% of Claim Amount
	Extension 2	Cover for Pedal Cycle				5% of Claim Amount
	Extension 3	Cost of Study upon Accidental Death of Parents				Not Applicable
	Extension 4	Ambulance Charges				Not Applicable
	Extension 5	Compassionate Visit				Not Applicable
	Extension 6	Reimbursement of Examination Fees				Not Applicable

(iii) Section - B- Medical Cover

Sr. No.	Benefit I	Y/N	Sum Insured	Premium
Benefit I	Medical Cover for the Student			

Details of Risk for Section C

(iv) Base Cover & Extensions

Section C		Y/N	Sum Insured	Premium	Default Deductible
	Fire And Allied Perils (excluding STFI and RSMD)				5% of Claim Amount for Perils subject to minimum of Rs. 10,000 Deductible and Rs. 10,000 for other perils
Staff Secure		Y/N	Sum Insured	Premium	Default Deductible
Extension 1	(i) Death				Not Applicable
	(ii) Permanent Total Disablement				Not Applicable
	(iii) Permanent Partial Disablement				Not Applicable
Library Books		Y/N	Sum Insured	Premium	Default Deductible
Extension 2					5% of claim amount Subject to minimum of Rs.5000

12. Whether you have insured the same property with any other Insurance Company with identical coverage. (Give details)

13. Whether Insurance cover was declined by any other Company or imposed any Special Conditions (Give details)

14. Claims experience- Fire and Allied Perils

Month/Year	Insurer	Premium Paid	Incurred Claims (reserved+outstanding)	Cause of Loss

15. Details of Fire Extinguishing appliances installed

Portable Extinguishers

Y N

Trailer Pumps

Y N

Fire Engine

Y N

Hydrant System

Y N

Sprinkler System

Y N

Fixed Water Spray System

Y N

16. Details of values as on date, proposed Sum Insured(s) and Locations. (Please include "Kutchha construction" buildings also in this description.

Sr. No.	Description of Property	Building 1	Building 2	Building 3
1	Building			
a	Value			
b	Proposed SI			
c	Location			
2	Furniture, Fixtures And Fitting			
a	Value			
b	Proposed SI			
c	Location			
3	Machinery and Equipment			
a	Value			
b	Proposed SI			
c	Location			
4	Library Books (if extension is opted)			
a	Value			
b	Proposed SI			
c	Location			

17. Construction Details for each of the building insured (including "Kutchha construction"

a. Please state the Material used	Walls :
	Floor :
	Roof :
b. Height of the Building	In Meters :
	Numbers of Floors :
c. Age of Building	Less than 5 years :
	5-10 years :
	10-20 years :
	20 and above :

18. Are any hazardous goods kept in the building? _____ If so, state details and quantity.

19. Do you want cover on Reinstatement Value basis?

Y N

Staff Details

20. Number of Staff members proposed to be covered under this insurance?

21. Please provide break - up of staff as per their subjects/ work related activities of Studies: _____

22. Does the discipline taught by them require manual work?

Y N

If answer to above question is "Yes", please provide details on a separate sheet.

23. Indicate percentage of the proposed staff falling under below mentioned age brackets:

18-25 years old	
25-45 years old	
45-60 years old	
60-70 years old	
70-80 years old	
Above 80 years old	

24. Benefit details for the Staff

Capital Sum Insured for the Staff: _____

For Death: 100% of CSI

For Permanent Total Disablement : 100% of CSI

For Partial Permanent Disablement: as per % of disability

25. Type of Policy: Single Premium

Premium:

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(ii) Extensions under section A

If you want to avail any of the following extensions under section A of the Policy by the payment of additional premium, please specify:

26. Payment of claim: Lump Sum/ Periodical

Periodical claim payment: Payment of claim in case of Death / PTD / Cost of Study for _____ periods up to Rs. _____ per period

27. Cover required:Worldwide basis/ Geographical Area

Kindly specify the geographical area (countries / locations) for which the cover is applicable: _____

28. Is cover required on "On Premises basis"?

Y N

29. Premium Details

Basic Premium :	(Rs)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Extension Premium :	(Rs)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Total Premium :	(Rs)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Less: Discount (if any) :	(Rs)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Net Premium :	(Rs)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Add: Service Tax* and Education CESS (as applicable) :	(Rs)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Total payable premium:	(Rs)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

DECLARATION

1. "I/We 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/We am/are authorized 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 insurance company and that the policy will come into force only after full receipt of the premium chargeable.
3. 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.
4. I/We declare and consent to the company seeking medical information from any doctor or from a hospital who at anytime 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.
5. 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."

Dated at _____ this _____ day _____ of _____ 20 _____

Please Note:The liability of the company does not commence until the acceptance of the proposal has been formally intimated by the Company.

PROHIBITION OF REBATE -- Section 41 of the Insurance Act 1938

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 of risk relating to lives or property in India, any rebate of the whole 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 rebates 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 Ten Lakhs Rupees.

Proposer's Signature

USE IF FILLED BY SCRIBE

DECLARATION

(APPLICABLE ONLY WHERE FORMS FILLED IN BY A SCRIBE* OR FOR FORMS SIGNED IN VERNACULAR LANGUAGES)

I _____ (Full Name), have explained to the Proposer, that the answers to the questions form the basis of the contract for _____ Policy between the Company and the Propose Policyholder and that if any untrue statement is contained therein the Company shall have the right to vary the benefits which may be payable and further if there has been a nondisclosure of a material fact the policy may be treated as void and all premiums paid under the policy may be forfeited to the Company. I also confirm that the Propose Policyholder has signed / affixed his/her right thumb impression in my presence.

I, the Propose Policyholder declare that the contents in the proposal form and documents have been fully explained to me and I have fully understood the significance of the proposed contract.

ADDRESS OF SCRIBE

City/Village

State

Place

Pin

Date

Signature of the Scribe

*Scribe is a person not connected with the Company

Signature / Right Thumb Impression of the Policyholder Proposer

Signature of / Broker as witness

USE IF FILLED BY OTHER THAN SCRIBE

IN CASE THE PROPOSED INSURED/PROPOSER IS ILLITERATE OR IS SIGNING IN VERNACULAR OR IF FORM HAS BEEN FILLED BY AGENT/EMPLOYEE / SPECIFIED PERSON/ BROKER ON BEHALF OF THE PROPOSER/PROPOSED INSURED

I, (_____) (_____) hereby declare that I have read & explained the contents of

Name of the Agent/Specified Person/Broker/Employee

Agent/Specified Person/Broker/Employee Code

the proposal form to the Proposed Insured/ Proposer in language and that I have read out to the Proposed Insured/ Proposer, the answers to the questions dictated by the Proposed Insured/Proposer. The information/answers filled in the proposal form by me on behalf of the Proposed Insured/ Proposer are exact replication of the information/answers provided to me by the Proposed Insured/Proposer and that the Proposed Insured/ Proposer has signed/affixed his/her thumb impression on the proposal form after fully understanding the contents thereof. I further declare that there is no addition/ deletion/alteration done by me to the information/answers provided by the Proposed Insured/ Proposer.

Signature of Agent/Specified Person/Broker/Employee

Signature/Thumb Impression of Proposed Insured/ Proposer

Witness Details:

Name : _____

Signature : _____

ID Proof Type : _____

ID Proof Number : _____

Go Green

I would like to protect my environment and would like to help save paper by authorising Universal Sompco General Insurance Co Ltd to send all my Policy and service related communication to the email id as mentioned in this form

Universal Sompco 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 | Tel No.: 022 41690888/41690999

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