

## PROPOSAL FORM ICICI Lombard Accident Care Policy

We would like to inform you that Bharti AXA General Insurance has merged with ICICI Lombard General Insurance w.e.f. Sept 8,2021. Enjoy our seamless services while exploring our enhanced offerings and diverse non-life insurance solutions

1. To be filled in by Proposer in CAPITAL LETTERS only.
2. ICICI Lombard General Insurance Company Limited (the "Company") is under no obligation to accept any proposal for insurance and to issue a policy by the mere submission of a completed proposal form or due to any payment for any policy. The Company retains the right in its sole and absolute discretion to issue a policy. The liability of the Company does not commence until this Proposal has been accepted and underwritten by the Company and premium received, including loadings, if any. You understand and agree that if the Company accepts a proposal for insurance, it shall be subject to the Policy Terms and Conditions and the Company shall have no liability whatsoever if the premium is not realized, or received in full or in time. In the event the Company does not accept the proposal, you will be informed of the same and the premium received from you, if any, will be refunded without interest.
3. If there is insufficient space, please provide further details on a separate sheet. All attached documents form part of this Proposal.
4. The proposed policyholder will be referred to in this Proposal Form as "Proposer", "You" or "Your".

### 1. PROPOSER DETAILS

Proposer: (Mr/Mrs/Ms)		First Name		Middle Name		Last Name	
Date of Birth - DD/MM/YYYY							
Address:						City/Town:	
District:						State:	
Pin Code:						Mobile:	
Telephone:						E-mail:	

Nationality \_\_\_\_\_ Marital Status \_\_\_\_\_

ID Proof Type: PAN Passport Driving License Voter's Card If Other, please specify \_\_\_\_\_

ID Proof No.:

PAN Number is mandatory in case premium is > 1,00,000 (irrespective of mode of payment) or >50,000 accepted in cash

Existing ICICI Lombard Policy Owner, Kindly enter policy number / client id

Policy no

Client ID

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:

i) Name of Insurance Repository :	<input type="text"/>
ii) eIA No :	<input type="text"/>
iii) Name as appearing in eIA :	<input type="text"/>

If you do not have an eIA, would you like to open an account? Yes

No If Yes, choose any one Insurance Repository:

NDML - NSDL Data Management Limited	CAMSRP- CAMS Repository Services Limited
Karvy Insurance Repository Limited	CIRL-Central Insurance Repository Limited (CDSL)

### 2. PLAN DETAILS

Plan Details	1	2	3	4	5			
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Proposed Policy Period Start Date :	D	D	M	M	Y	Y	Y	Y	
Sum Insured (in Rs.) :									Tenure : 1/2/3 years/ Event Based
SECTIONS (TO BE ALLOWED AS PER PLAN OPTED BY CUSTOMER ABOVE)	Yes		No		Sum Insured		Deductible/ Co Pay/ Franchise		
ACCIDENTAL DEATH									
PERMANENT TOTAL DISABLEMENT									
PERMANENT PARTIAL DISABLEMENT									
TEMPORARY TOTAL DISABLEMENT									
BROKEN BONES									
BURNS									
COMATOSE BENEFIT									
DISAPPEARANCE									
ADVENTURE SPORTS BENEFIT									
IN-HOSPITAL MEDICAL EXPENSES (INPATIENT)									
IN-HOSPITAL MEDEX (INPATIENT)									
OUTPATIENT MEDICAL EXPENSES									
OUTPATIENT MEDEX (OPD)									
HOSPITAL CASH									
HOME CONVALESCENCE									
REHABILITATION COVER									
RECONSTRUCTIVE SURGERY COVER									
EXTERNAL AIDS AND APPLIANCES									
ASSAULT									
ANIMAL ATTACK									
COMMON CARRIER									
LAST RITES COSTS									
TRANSPORTATION OF MORTAL REMAINS									
HOME & VEHICLE MODIFICATION									
AMBULANCE COST									
AIR AMBULANCE									
SPOUSE OR DEPENDENT CHILD CONSOLATION BENEFIT									
INSURED AND FAMILY COUNSELLING COVER									

MEDICAL EVACUATION COVER				
DEPENDENT CHILD EDUCATION BENEFIT				
WIDOWHOOD BENEFIT				
HOME TUITION BENEFIT				
PARENTAL CARE BENEFIT				
COMPASSIONATE VISIT				
LOSS OF JOB COVER				
LEGAL EXPENSES				
EMI PROTECTION COVER				
HEALTH INSURANCE PREMIUM INDEMNITY				
DEPENDENT CHILDREN MARRIAGE BENEFIT				

**3. DETAILS OF THE PERSON PROPOSED TO BE INSURED**

	Name of the Insured Person	Relationship to Proposer	Third Gender*	Date of Birth	Profession/Occupation	Capital Sum Insured	Nominee***
1.	Self		M / F	DD/MM/YYYY			Spouse
2.	Spouse		M / F	DD/MM/YYYY			Self
3.	Child 1		M / F	DD/MM/YYYY			Self
4.	Child 2		M / F	DD/MM/YYYY			Self

\* Gender Code M (Male), F (Female). \*\*\* Default Nominee is as mentioned in the table above. Fill in the table in section 4 if above is not acceptable.

Occupation Group I II III IV

Nature of Duties \_\_\_\_\_

Monthly income from gainful employment

**4. NOMINEE DETAILS**

In the event of the death of an Insured Person any payment due under the Policy shall become payable to the nominee in accordance with the Policy terms and conditions. The nominee must be an immediate relative of the Proposer. Nominee for any of the persons proposed to be insured shall be the Proposer.

Nominee Name	Relationship	Address of Nominee

\*If the Nominee is minor, Name and Address of Appointee and Relationship with Minor:

Appointee Name	Relationship	Address of the Appointee

A.

Please answer each of the following questions individually for each Insured Person by ticking the relevant box.	Insured Person 1	Insured Person 2	Insured Person 3	Insured Person 4
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 corporations or important political party officials.	Y/N	Y/N	Y/N	Y/N
Does your job require you to be involved with any hazardous activity, significant manual labor, operating heavy machinery, handling hazardous material, working at heights/underground /construction sites, oil rigging, high voltage, high temperature, working in aircrafts or sea -going vessels or adventure sports or armed forces? Please specify if any other profession.	Y/N	Y/N	Y/N	Y/N
Have you ever been diagnosed with or consulted a doctor or advised surgery for any of the following? Paralysis, Epilepsy/Fits, Physical disability/defects, Psychiatric disorder, defect in sight/hearing/speech. If yes, then please furnish disease name, date of diagnosis, disability %, Last consultation date, name of the surgery, details of treatment taken.	Y/N	Y/N	Y/N	Y/N

**6. DETAILS OF EXISTING PERSONAL ACCIDENT OR HEALTH INSURANCE POLICY**

Do you have an existing Personal Accident/Health Insurance Policy with any other Insurer?	Yes	No
(If yes, please provide the Insurer Name, Policy No., Plan Name and Sum Insured)		

**7. PAYMENT DETAILS:**

Premium Payment Frequency  Single Premium  Installment Premium

If installment premium is applicable (Select): Annual/Bi -annual/Quarterly/Monthly

Name of the Premium Payor:

Premium Amount (in Rs.) in Figures

Premium Amount (in Rs.) in Words

Relationship to proposer

Instrument type: Cash  Cheque/DD  Payment Gateway  Online banking (IMPS/NEFT/RTGS)  Others

Cheque/DD No

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Bank Name:

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Date:

D	D	M	M	Y	Y	Y	Y
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Branch

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Payment Gateway Link

[https:// www.billdesk.com/pgmerc/baxagenins/BAXAGENINSDetails.htm](https://www.billdesk.com/pgmerc/baxagenins/BAXAGENINSDetails.htm)

Account details for online banking

Account no: 99001914273934

IFSC Code: SCBL0036074

Bank Name: Standard Chartered Bank

Branch: Raheja Towers, M.G. Road, Bangalore - 560001

Sources of funds: Salary  Business  Other  \_\_\_\_\_  
(Please tick where applicable)

Please make a Crossed Cheque/DD/Pay Order in favour of 'ICICI Lombard General Insurance Company Limited' only.

\*PAN Card copy is Mandatory for premium of `50,000 and above accepted in Cash/DD or `100,000 and above by Chq/Credit/Debit Card

Payment to be collected only from Proposer's Card / Bank Account

#### 8. BANK DETAILS

As per the Regulatory requirements, we can effect payment of refund / claims only through Electronic Clearing System (ECS) / National Electronic Funds Transfer (NEFT) / Real Time Gross Settlement (RTGS) / Interbank Mobile Payment Service (IMPS). For this purpose please submit the following details of the insured's bank account \*

Name of the Account Holder:

Name of the Bank

Branch:

Type of Account : SB Account - \_\_\_\_ Current Account - \_\_\_\_ Others (please specify) - \_\_\_\_

Account Number:

IFSC Code of Bank :

If the premium cheque is not paid from the above mentioned account then a cancelled cheque leaf of the above mentioned account is to be attached. \*mandatory if annualized premium is more than Rs.25,000

Note: If premium paid through payment gateway, refunds will be credited back to same account from which customer made the payment to us

Section 41 of Insurance Act 1938 (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 of risk relating to lives or property in India any rebate of the whole or part of the commission payable or any rebate of 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 liable for penalty which may extend to ten lakh rupees.

Additional Information

(If there is insufficient space to provide additional relevant information, whether as requested or otherwise, please attach extra sheet duly signed.)

**9. DECLARATION & WARRANTY ON BEHALF OF ALL PERSONS PROPOSED TO BE INSURED**

- 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.
- I understand that the information provided by me will form the basis of 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/ 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.
- I/We declare and consent to the company seeking medical information from any 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 and mental health of the life to be insured/proposer and seeking information from any insurance company to which an application for insurance on the life to be insured/ proposer has been made for the purpose of underwriting the proposal and/or claim settlement.
- 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.

**10. Authorisation for electronic Policy fulfillment and service communications**

I hereby authorize ICICI Lombard General Insurance Company Limited to send all my Policy and service related communication to the email ID as mentioned here in the application form. Yes/No

I hereby consent to and authorize ICICI Lombard General Insurance Company Limited to make welcome calls, service calls or any other communication (electronic or otherwise) with respect to the proposed or existing Policy of Company from time to time. Yes/No

Signature of Proposer: \_\_\_\_\_

Date: \_\_\_\_\_

Place: \_\_\_\_\_

**11. VERNACULAR DECLARATION**

Certification in case the proposer has signed in vernacular (to be witnessed by someone other than agent/employee of the company):

Name of Proposer:

The content of this form and its particulars have been explained by me in vernacular to the proposer who has understood and confirmed the same.

Signature of Proposer: \_\_\_\_\_

Signature of the witness: \_\_\_\_\_

Date: \_\_\_\_\_

Name of the witness: \_\_\_\_\_

Place: \_\_\_\_\_

Insurance is the subject matter of solicitation

**12. AGENT'S DECLARATION**

Agent's Declaration

I, \_\_\_\_\_ in my capacity as an Insurance Advisor/ Corporate Agent/ Authorized employee of the Broker/ Relationship Officer, do hereby declare that I have explained all the contents of this Proposal Form, \_\_\_\_\_ along with the nature of the questions contained in this Form to the Proposer, including the fact that the statement(s), information and response(s) submitted by him/her in this Form to questions contained herein or any details sought herein will form the basis of the Contract of \_\_\_\_\_ Insurance between ICICI Lombard General Insurance 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 provided contained in this Proposal Form/ including addendum(s), affidavits, statements, submissions, furnished/ to be furnished to this \_\_\_\_\_ Proposal it may lead to cancellation of the policy benefits.

License No. (Advisor/ Corporate Agent/ Broker/ Relationship Officer): \_\_\_\_\_

Date: \_\_\_\_\_

Place: \_\_\_\_\_

Signature of Agent: \_\_\_\_\_

**13. Intermediary Details (To be filled by Intermediary)**

Application No / Proposal No	<input type="text"/>
Intermediary/Sales Officer Name	<input type="text"/>
Branch Name	<input type="text"/>
Sales Manager's Name	<input type="text"/>
Campaign Name	<input type="text"/>
Business Indicator	<input type="text"/>

**Acknowledgement**

	Application No / Proposal No.
Name of Proposer:	_____
We acknowledge with thanks the receipt of your application and amount by _____ cash/cheque/demand draft/others _____ of amount of Rs. _____	
Place: _____	Signature and Seal : _____
Date: _____	

INSURANCE IS THE SUBJECT MATTER OF SOLICITATION

For more details on risk factors, terms and conditions, please read sales brochure carefully, before concluding a sale

Registered office address:

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Mumbai – 400025, IRDAI Registration No: 115,  
CIN:L67200MH2000PLC129408,  
Toll Free no: 18001032292,  
Email Id: [customersupportba@icicilombard.com](mailto:customersupportba@icicilombard.com)  
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