ICICI Lombard
Nibhaye Vaade

Proposal Form
Smart Health Insurance Policy (Revision)

PLEASE ANSWER ALL QUESTIONS COMPLETELY

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

(The insurance is not effective until the proposal is accepted by the company and premium is -realized)

Proposer Details

Name: (Mr./Mrs./Ms./Dr.)	**First Name**	**Middle Name**	**Last Name**
Address:			
		City/Town:	
District:		**State:**	
Pin Code:		**Mobile:**	
Contact Number :		**Email ID:**	

Nationality: _____ **Marital Status:** _____ **Annual Income:** _____

Profession: ☐ Salaried ☐ Self Employed ☐ Others, Please Specify:

ID Proof: ☐ PAN ☐ Passport ☐ Driving License ☐ Voter ID ☐ ☐ Others, Please Specify:

_____

Plan details / Variants

Individual ☐ Family Floa ☐

Family Floater option: ☐ 2 Adults ☐ 2 Adults+1 Child ☐ 2 Adults+2 Children ☐ 1 Adult+1 Child ☐ 1 Adult+2 Children ☐ 1 Adult

Policy Period ☐ One Year

Sum Insured 1 Lakh 2 Lakhs 3 Lakhs 4 Lakhs 5 Lakh

Sl. No.	Name of the Insured Person	Gender	Height	Weight	Date of Birth	Sum Insured Opted	Relationship
1		M/F/Third Gender			DD/MM/YYYY		
2		M/F/Third Gender			DD/MM/YYYY		
3		M/F/Third Gender			DD/MM/YYYY		
4		M/F/Third Gender			DD/MM/YYYY		

Nominee Details

In the event of the death of an Insured / Insured Person any -claim 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 the Nominee

Existing / Previous Insurance Details

UIN of Product: BHAHLIP21454V022021, **URN:** BhartiAXAGI/SHIP(R)/2020-21/V01
Registered and corporate office address: ICICI Lombard General Insurance Company Ltd., ICICI Lombard House, 414, Veer Savarkar Marg, Prabhadevi, Mumbai – 400025, IRDAI Registration No: 115, CIN: L67200MH2000PLC129408, Telephone: 18001032292, Website: www.bharti-axagi.co.in, Email: customersupportba@icicilombard.com

Is the proposer or the persons proposed, already insured under a health plan with ICICI Lombard General Insurance Company Limited or any other insurance company? If yes, please share below the Policy/ Application number(s). Please mention application number in case of pending proposal.
Do you want us to consider these details for portability? ☐ Yes ☐ No

Name of the Insurer	Policy / Application No.	Period of Insurance		Sum Insured	Claims lodged during the preceding 3 years	Cumulative Bonus
		From Date	To Date			
		D D M M Y Y Y Y	D D M M Y Y Y Y			
		D D M M Y Y Y Y	D D M M Y Y Y Y			
		D D M M Y Y Y Y	D D M M Y Y Y Y			
		D D M M Y Y Y Y	D D M M Y Y Y Y			

Medical and Life Style Information

Medical History: Please answer the below mentioned questions Yes (Y) / No (N) individually for all insured members

	Section A : Have Insured/ Insured person(s) suffered from/are currently suffering from any of the following:	**Insured Person 1**		**Insured Person 2**		**Insured Person 3**		**Insured Person 4**	
		Y	**N**	**Y**	**N**	**Y**	**N**	**Y**	**N**
I	Have you suffered from or are you currently suffering from any disease, illness, disability, injury or accident or advised/ consuming medication or undergone/advised/ awaiting any surgical procedure (other than Normal /assisted Delivery or Caesarean section without any complication) or undergone any investigations, in the past 4 years?								
II	Have you ever had or has a doctor ever said that you have any of the following conditions / diseases -: High or low blood pressure, diabetes or sugar, any heart related ailment, brain stroke, Paralysis, TB or asthma or breathing problem, tumor or cancer, liver or gall bladder diseases, stomach or Duodenal disorder prostrate, intestinal tract disorder, kidney or stone diseases, arthritis or bone disease, blood diseases or disorders, Eye or ENT disease, dizziness or fits, HIV/AIDS / any other sexually tansmitted disease, Ulcer (Stomach / Intestine), Anaemia, Leukaemia or any other blood/lymphatic system disorder, multiple sclerosis, epilepsy, tremors, paralysis, psychiatric/mental illnesses or sleep disorder, Thyroid/Pituitary disorder / disease or any other endocrine disorder / disease, Psychiatric/ Mental illnesses or sleep disorder / disease, Heamophilia, cystic fibrosis, down syndrome, sickele cell, polycystic kidney disease or any other genetic disorder / disease, Dysfunctional uterine bleeding, Fibroid, Cyst / Fibroadenoma or any other Gynaecological / Breast disorder, or suffered from any congenital disease, anamolies like congenital Heart disease, cleft palate or any other disorder / disease .								
III	Have you or any other member(s) proposed to be insured taken any medication for more than 2 weeks in last 5 years?								
IV	Has any application for life, Health or critical illness insurance ever been declined, postponed, loaded or been made subject to any special conditions by any insurance company?								
V	Please confirm, if any of the person to be insured is								

	pregnant? If yes, please answer as below:- a) Duration in weeks b) Expected delivery date c) Any complications during previous pregnancy?								

Section B : Have Insured/ Insured person(s):	**Insured Person 1**		**Insured Person 2**		**Insured Person 3**		**Insured Person 4**	
	Y	**N**	**Y**	**N**	**Y**	**N**	**Y**	**N**
Been addicted to alcohol, narcotics, habit forming drugs or been under detoxication therapy or smoke or consume Gutka/ Pan Masala/ alcohol?								

Please provide details if yours or any of the insured member's response is 'Y'.	**Insured Person 1**	**Insured Person 2**	**Insured Person 3**	**Insured Person 4**
Smoke (No of Sticks)				
Alcohol (No of pegs / Beer Bottles) (Each Peg is 30 ml)				
Pan Masala (No of Pouches)				
Others				

Section C: Please provide details if yours or any of the insured member's response is 'Y' to the question(s) in **Section A**

Insured Name	Name of Pre-Existing Diseases/ Illness/ Surgery	Diagnosis Date	Date of last consultation	Treatment Inpatient / Outpatient	Doctor/Hospital Name & Phone No.
		DD/MM/YYYY	DD/MM/YYYY		
		DD/MM/YYYY	DD/MM/YYYY		
		DD/MM/YYYY	DD/MM/YYYY		
		DD/MM/YYYY	DD/MM/YYYY		
		DD/MM/YYYY	DD/MM/YYYY		

Premium Payment Details

Instrument Type: Cheque ☐ Demand Draft ☐ Debit Card ☐ Cash ☐ Credit Card ☐ Others: _____

Name of the Premium Payer	Instrument No. (DD/Cheque/Card No.)	Date	Bank Name	Amount (Rs.)

Please note: Wherever AML guidelines are applicable, PAN card and Address proof copies are required

Prohibition of Rebates (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 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 provision/s of this section shall be punishable with fine, which may extend to Ten lakhs rupees.

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Declaration(s)

1. 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 authorised 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 insurer and that the policy will come into force only after full payment of the premium chargeable.
3. 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.
4. 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.
5. 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."

Date:

Place: Proposer's / Insured's
Signature

Authorization for electronic Policy fulfillment and service communications

I would like to protect my environment and would like to help save paper by authorizing 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
(Note : Please tick this option if you wish to receive your Policy at the e-mail address mentioned by you in this proposal form)

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

Date:

Place: Proposer's / Insured's
Signature

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 the 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 / Insured:_____ Signature of witness: _____

Date:_____

Place: _____

Name of witness:
_____

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 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:_____

Checklist

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

1. ID Proof : Passport/ PAN Card/ Voter ID/ Driving License/ Aadhar Card/ Letter from a recognized public authority
2. Address Proof: Electricity Bill/ Ration Card/ Telephone Bill (not more than 6 months old)/ Current bank passbook/ Letter from any recognized public authority
3. Age Proof : Proof of Age
4. Renewal Notice(s) with claim details
5. Photocopies of all previous policy schedules and endorsements

For office use only

ICICI Lombard Office Name & Code:
_____

Branch Receipt Date:
_____

Sales Manager's Name & Code:
_____

Initiative Name & Code: _____

Business Indicator:
_____

Rural Indicator: Yes/ No

Intermediary Code:
_____

Whether medical test required? ☐ Yes ☐ No

If yes, please mention date of medical examination

D	D	M	M	Y	Y	Y	Y

Whether proposal has been approved ☐ Yes ☐ No

If yes,

1. Please indicate premium: _____
2. Date of approval: ___/_____/ _____
3. Period of Insurance: ___/___/____ to __/___/_____
4. Special conditions, if any:

_____

If no, please mention the reason for not accepting the proposal:

_____

Acknowledgement

Application 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: _____

Neither the submission to us of a completed proposal for insurance nor any payment for any Policy sought obliges us to agree to issue a Policy, which decision is and always shall be in our sole and absolute discretion. If we accept a proposal for Insurance, it shall be subject to the Policy terms and conditions and we shall have no liability to make any payment if the premium is not received by us in full and in time, or is not realized or non-fulfillment of Health Check-up. If we do not accept the proposal, we will inform you and refund the -premium received from you without interest within next 30 days.

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

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