MASTER PROPOSAL FORM - Smart Health

Proposal form filling instruction:

1. Kindly fill in the form in CAPITAL LETTERS only. 2. Please select the option by ticking the relevant box in the Proposal Form. 3. This proposal form is to be filled, dated, signed and sealed in by the Proposer/ its authorized representative only. 4. It is essential to provide all information / details asked in this proposal form. All questions are required to be answered fully and correctly. 5. Please use additional sheet in case the space in the proposal form is not sufficient to fill in the details. The additional sheets/ information provided externally along with this Proposal Form would form a part of the Proposal Form. 6. Please strike off whichever is not opted.

1. Proposer's details:

Name of Proposer

Proposer's Trade/Business

Key Contact Person | Designation

Address for Correspondence

City | District

State

Mobile No. | Alternate Number | Pin-code

Email ID

PAN No. | GST No.

Do You want Physical Copy of the Policy Kit? ☐ Yes ☐ No

2. Coverage details:

I. Policy Period:

Proposed Policy Start Date (D D M M Y Y Y Y) | Proposed Policy End Date (Midnight) (D D M M Y Y Y Y)

II. Number of persons to be insured

III. Categories of proposed insured (Add more categories if needed) – brief description for e.g. senior management, middle management)

1. Cat 1
2. Cat 2
3. Cat 3
4. Cat 4
5. Cat 5

IV. Is selection of coverage involved | V. Is the premium paid by the member

VI. Premium Payment Frequency

VII. Free look period

VIII. Please provide the details of benefits opted for all members:
(All Sections are optional. Please select only the required section)

	Category 1	Category 2	Category 3	Category 4	Category 5
No. of proposed Insured					
Benefits					
A. Hospitalization Cover:					
Plan (Individual/ Floater/ Combination)					
Relationships covered if floater opted					
Tenure of the policy					
Entry Ages					
Other Plan details (loan linked/non-loan linked etc)					
Is coverage taken for specific illnesses/conditions/ailments? *(Please mention Yes/No with details)*					
Base Sum Insured					
Annual Aggregate Deductible (If Opted)					
Catastrophic Claim Deductible (If Opted)					
In-patient Care (Option 1, Option 2 or Option 3)					
Hospital Accommodation (Room Rent per day)					
Hospital Accommodation (ICU per day)					
Daycare Treatments (Please mention Option 1 or 2 and limits chosen)					
Pre hospitalization Medical Expenses					
Post hospitalization Medical Expenses					
Alternative Treatments					
Domiciliary Hospitalization					
Organ Transplant					
Critical Illness Multiplier Indemnity Cover					
Maternity Cover					
New Born Baby Cover					
New Born Vaccination Cover					
Well mother cover					
Well Baby cover					
Pre and post natal expenses					
Cord blood banking cost cover					
Emergency Ground Ambulance- Within India					
Air Ambulance Cover- Within India (one transfer per Hospitalization)					
Prosthetic Cover					
HIV Cover					
Nursing Allowance					
Animal/serpent attack					
Mental Illness Cover					
Compassionate visit					
Accompanying person accommodation cover					
Health Check-up					
Emergency assistance services					
Sub-limit on specified illness/conditions (As mentioned in the COI/Policy Schedule)					
Loyalty Credit					
No Claim Bonus					
Re-Assure Benefit					
Empathy Benefit					
Weekly Benefit					

Co-Payment (applicable only for Hospitalization Cover. Please mention conditions applicable)					
Physiotherapy and Rehabilitation cover					
Modern treatments (Indicative list - in annexure)					
Corporate Floater (items/diseases/conditions/procedures/ treatments/syndromes)					
Corporate Floater for any of 65 Critical Illness					
Claim settlement in Network only					
Claim settlement on reimbursement only					
Home Health Care services					
Pre-existing Waiting Period					
Specific Illnesses Waiting Period					
Initial Waiting Period					
B. Fixed Benefit Coverage for Named Illness:					
Plan Type					
Relationships Covered					
Policy Tenure					
Entry Age					
Other Conditions/Details					
Sum Insured & Option					
Waiting period for Pre-Existing Diseases (PED)					
Waiting Period for specific disease					
Initial Waiting Period					
C. Hospital Cash Benefit					
Plan Type					
Relationships Covered					
Tenure of the policy					
Entry Age					
Other Plan details (loan linked/non-loan linked etc)					
Daily Cash Benefit					
ICU Cash Benefit (Can be opted only if Daily Cash Benefit is opted)					
Accidental Hospital Cash Benefit					
Accidental Hospital ICU Cash Benefit *(Can be opted only if Accidental Hospital Cash Benefit is opted)*					
Waiting period for Pre-Existing Diseases (PED)					
Waiting Period for specific disease					
Initial Waiting Period					
D. OPD Treatment and Other Services					
Plan Type					
Relationships Covered					
Tenure of the policy					
Entry Age					
Other Plan details (loan linked/non-loan linked etc)					
Combined OPD Wallet Limit (If Opted)					
Video Consultations					
Tele Consultations					
Physical Consultations (GP)					
Physical Consultations with Specialists					
Video -Consultations with Specialists					
Tele -Consultations with Specialists					
Diagnostic Services					
Pharmacy					
OPD Procedures					

Home Care Service					
Second Medical Opinion					
Vaccinations					
Waiting period for Pre-Existing Diseases (PED)					
Initial Waiting Period					
Waiting Period for specific disease					
E. Accidental Cover					
Plan Type					
Relationships Covered					
Tenure of the policy					
Entry Age					
Other Plan details (loan linked/non-loan linked etc)					
Accidental Cover Sum Insured (SI)					
Outstanding Loan Cover – Accident only (Loan linked scenario)					
Accidental Death (AD)					
Accidental Permanent Total Disability (PTD)					
Air Accident Death					
Last rites Expenses					
Repatriation of Mortal remains					
Common accident					
Residential or Vehicle Modification allowance					
Accidental Permanent Partial Disability (PPD)					
Temporary Total Disability (TTD)- Weekly					
Accidental Medical Reimbursement					
Rehabilitation cover					
Ambulance charges					
Evacuation					
Education Allowance for children					
Animal Attack					
Parental Care Benefit					
Family Counselling					
Family Transportation to the place of Insured Persons's hospitalization					
Broken Bones					
Child Wedding					
Burns					
Medical Insurance Premium Indemnity					
Air Ambulance for Accidental Injuries					
Comatose benefit					
Outstanding Loan Cover (Loan linked scenario)					
Home Tutor Expense - Weekly					
Assault					
Chauffeur Benefit					
EMI Cover					
Loss of Job					
Reconstructive Surgery					
Physiotherapy charges following accidental injury					

F. Critical Illness Benefit:					
Plan (Individual/ Floater/ Combination)					
Relationships covered if floater opted					
Tenure of the policy					
Entry Age					
Other Plan details (Loan linked/non-loan linked etc)					
Critical Illness Sum Insured					
No. of Critical Illness Opted (As per the PBT attached)					
Outstanding Loan Cover - Critical Illness only (Loan linked scenario)					
Sum Insured Enhancement					
Personal Counselling					
Family Counselling					
Income Protector					
EMI Cover					
Loss of Job					
Staggered Payout					
Death Benefit (Death followed by CI within survival period)					
Second Medical Opinion for Critical Illness					
PED Waiting Period					
Initial Waiting Period					
Survival Period					
G. Wellness Cover:					
Plan (Individual/ Floater/ Combination)					
Relationships covered if floater opted					
Tenure of the policy					
Other Plan details (Entry ages, loan linked/non-loan linked etc)					
Pharmacy Services					
Diagnostic centre					
OPD Services					
Personalized health coaching					
Other Healthcare Services					
H. Other Cover:					
List of benefits being provided and their details					
Additional conditions applicable					

3. Past Insurance Policy details: (Up to last 3 years if applicable)

Policy Period From – To	Name of the Insurer	Policy number	Number of members covered	Total premium (Rs.)	Total amount of claims (Paid+Outstanding) (Rs.)

4. Declaration:

☐ 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/us are true and complete in all respects to the best of my / our knowledge and that I/We am/are authorized to propose on behalf of these other persons.

☐ I/We understand that the information provided by me / us 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 further consent to the Company seeking medical information from any doctor or hospital who/which at anytime 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.

☐ I/We authorize the Company to share information pertaining to my / our 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 and/or our empaneled provider.

Dated _____

Place _____ Signature of Proposer _____

5. Proposer Declaration:

(Certification where for any reason, the proposal form and other connected papers are not filled in by the prospect).
The contents of the proposal form and connected documents have been fully explained to me and I have fully understood the significance of the proposed contract. The proposal form is filled by _____ under my instruction and I found it to be correct.

Signature of Proposer _____

6. Vernacular Declaration:

Certification in case the Proposer has signed in vernacular (to be witnessed by someone other than agent/employee of the Company). 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.

Name of the Witness: _____

Signature of the Witness _____ Signature of the Declarant _____

7. Statutory Warning:

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 of 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 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 Lakh Rupees.

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Acknowledgement

We acknowledge with thanks the receipt of your proposal and amount by Cash/Cheque/Demand Draft/Others _____ of amount of Rs_____dated___/___/_____ drawn on_____

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 whatsoever if premium is not received by Us in full and in time or is not realized. If we do not accept the proposal, we will inform you and refund the payment, if any, received from you without interest.

Signature of the receiver and official seal _____