

For Agent Use Only:

IMD Code	IMD Name

MICRO CARE ACCIDENT AND HOSPITAL CASH POLICY PROPOSAL FORM

Instructions for filling up the form

1. Please answer all questions in BLOCK letters
2. The Liability of the Company does not commence until this Proposal has been accepted by the Company and premium has been paid
3. This Proposal will be the basis of any subsequent policy that we issue to you. It is therefore essential that you provide all the information in this Proposal FULLY AND ACCURATELY and that you provide us with any and all additional information relevant to risk to be insured or our decision as to acceptance of the risk or the terms upon which it should be accepted

Proposer Details

- | | | |
|-----|--|-------------------|
| 1. | Name of the Proposer/Group Administrator/ Policy holder (in full) | |
| 2. | PAN/TAN no. | 3. UID/Aadhaar no |
| 4. | Address | |
| | | |
| | | |
| | State | Pin Code |
| | E mail ID | |
| 5. | Description of the Proposer's Business | |
| 6. | Please mention detail of the Group/ Association/ Institution/ Corporate Body whose members are being covered under the Policy? | |
| 7. | Please state whether all eligible members of the Group/ Association/ Institution/ Corporate Body are proposed for Insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| 8. | Please mention the Total number of persons to be covered: _____
(Please attach the list of persons to be covered as per the format attached) | |
| 9. | Have you provided complete details of members in Annexure I? <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| 10. | Proposed Policy Period: From ___/___/____ To ___/___/____
(Long term policy of 1/2/3/4/5 year will be provided only to loan borrowers insured by financial institutes/ Banks) | |
| 11. | Plan opted <input type="checkbox"/> Plan I Micro Care <input type="checkbox"/> Plan II Micro Care Plus | |
| 12. | Optional Covers | |
| I. | Hospital cash <input type="checkbox"/> Yes <input type="checkbox"/> No | |


Annexure I

LIST OF PERSONS PROPOSED FOR INSURANCE

[illegible]

Sr. No.	Name of the Employee/ Member	Emp. code (if applicable)	Names of Employee's / Member's family members to be covered	Relationship of the dependent members to the Employee / Member	DOB (DD-MM-YYYY)	Gender	Details of the Plan opted (Micro Care/Micro Care Plus)	Optional Cover Hospital cash (Yes/No)	Nominee	Nominee Relationship with Insured
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1. Please attach additional sheets, if space not sufficient to complete details.
2. Names of the family members to be covered should be mentioned immediately after the name of each employee/ Member

Payment Details Mode of Payment: <input type="checkbox"/> Cheque <input type="checkbox"/> DD <input type="checkbox"/> Cash <input type="checkbox"/> Others Cheque - Given by: <input type="checkbox"/> Spouse <input type="checkbox"/> Father <input type="checkbox"/> Mother <input type="checkbox"/> Son/Daughter <input type="checkbox"/> Employer/Employee <input type="checkbox"/> Financier						
 To support our Go Green initiative, we will send policy copy link on your registered mobile number / email id. This is a digitally signed valid document. Please tick the box, if you still want to receive physical copy of your insurance policy. <input type="checkbox"/>						

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/We 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 purpose of underwriting the proposal and/or claim settlement.

Date: _____

Place: _____

Thumb impression /Signature of the Proposer

Certified that the contents of the Proposal Form and documents have been fully explained to the Proposer and that he/they have fully understood the significance of the proposed contract**

Date: _____

Place: _____

Signature (On behalf of Proposer)

*Please read declaration wordings carefully before signing the proposal form.

**This is required only where, for any reason, the Proposal Form and other connected papers are not filled by the Prospect/Proposer.

Section 41 of Insurance Act 1938 as amended by Insurance Laws Amendment Act, 2015 (Prohibition of Rebates):

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 a policy accept any rebate, except such rebate as may be allowed in accordance with the published prospectus or tables of the insurer. Any person making default in complying with the provisions of this section shall be punishable with fine which may extend to rupees ten lakh.

DECLARATIONS – PHYSICAL PROPOSAL FORM

- Are you or any of the proposal applicants a PEP* or a close relative of PEP*?

If yes, please share the details _____

“Politically Exposed Persons” (PEPs) are individuals who are or have been entrusted with prominent public functions in a foreign country, e.g., Heads of States/Governments, senior politicians, senior government/juridical /military officers, senior executives of state-owned corporations, important political party officials, etc.” ☐ Yes / ☐ No

- I/we hereby give my/our consent to the Company to verify and obtain my/our identity/address proof through Central KYC Registry or Goods and Service Tax Portal or Ministry Of Corporate Affairs Portal or National Securities Depository Limited portal for the purpose of undertaking KYC. ☐ Yes / ☐ No

- I/we hereby agree and ensure to maintain details of all the beneficiaries covered under the policy and shall share the same with the Company as and when required. ☐ Yes / ☐ No

- I/We hereby give voluntary consent to BAGIC/Company to share my/our personal information and data provided in this proposal form with its group companies or any other person in connection with the Insurance Policy or otherwise, including for providing products and services of group companies that may be of interest to me/us, to be used in accordance with their respective privacy policies and subject to appropriate measures being in place to safeguard my/our personal information. ☐ Yes / ☐ No