HEALTH INSURANCE PROPOSAL FORM (INDEMNITY)

For Official Use Only

Policy: 4128 (ILCHI) ☐ 4113 (HCP) ☐ Proposal No.:

Intermediary ID : Intermediary Name :

Branch Name : Deal No. :

GUIDELINES FOR COMPLETION OF THE FORM (To be filled by proposer)

Please answer all the questions fully and correctly. Where any question does not apply, please mention clearly that the same is not applicable.

Insurance is a contract of Utmost Good Faith requiring the Insured not only to disclose all material facts but also not to suppress any material facts in response to the questions in the proposal form.

The Policy shall become void at the option of Insurer, in the event of any untrue or incorrect statement, misrepresentation, non-description or non-disclosure in any material particular in the proposal form/personal statement, declaration and connected documents or any material information having been withheld by the Proposer or any one acting on his behalf. Kindly contact the Company's Offices or Agents for any doubts or clarifications on the proposal form.

Terms and Conditions

- Initial waiting period of 30 days for all illnesses (except Hospitalization due to injury)
- Specific waiting period of first two years for specific illnesses and treatments (mentioned in the policy wording)
- Pre- existing conditions/ diseases declared and accepted by the us will be covered immediately after 2 years/ 4 years of continuous coverage under the policy (4 years applicable only for 2 lakh Sum Insured)
- Sum Insured can be increased at the time of renewal only. Company reserves right to approve/ reject the increase in Sum Insured. Increased Sum Insured amount will be subject to fresh waiting period.
- Factors determining the renewal premium are (i) age slab of the senior most insured member at the time of renewal (ii)any change in the renewing policy.
- The liability of the Company does not commence until this Proposal has been accepted by the Company and premium realised.

Signature of proposer/ customer: _____ Date: D D / M M / Y Y Y Y Place: _____

PROPOSER / CUSTOMER INFORMATION

Proposer's Name (please leave a space after each part of name)

Mr. / Ms. / Dr. : FIRST MIDDLE LAST

Date of Birth : D D / M M / Y Y Y Y Gender : Male ☐ Female ☐ Marital Status : Single ☐ Married ☐

Occupation :Salaried ☐ Self Employed ☐ Professional ☐ Others ☐ Details _____

Nationality: ☐ Indian ☐ Others (please specify) _____

Residential Status: ☐ Indian Resident ☐ Non Resident Indian

Educational Qualifications: ☐ Lesser than matriculation ☐ Matriculation ☐ Graduate ☐ Post-graduate ☐ Professional Course

Annual Income : ☐ Less than 5 Lacs ☐ Between 5 - 10 Lacs ☐ Between 10 - 20 Lacs ☐ 20 Lacs and above

PAN Card No.: Passport No. Adhar No.

Correspondence Address :

Landmark :

City : State : Pin code :

Landline Number (with STD Code) : Mobile Number* :

E-mail address :

Permanent Residence Address :

Landmark :

City : State : Pin code :

*Kindly provide the details to enable us to serve you better

NOMINEE DETAILS

Name of Nominee : FIRST MIDDLE LAST

Relationship : Date of Birth : D D / M M / Y Y Y Y

FAMILY PHYSICIAN DETAILS

Name of Physician : FIRST MIDDLE LAST

Landline Number (with STD Code) : Mobile Number :

DETAILS OF PERSONS TO BE INSURED

Insured No.	Full Name (First, Middle, Last)	Gender (M/F)	Date of Birth (DD/MM/YY)	Relationship with Proposer	Height (feet / inch)	Weight (kgs)	PAN No.
1.			D D / M M / Y Y Y Y				
2.			D D / M M / Y Y Y Y				
3.			D D / M M / Y Y Y Y				
4.			D D / M M / Y Y Y Y				
5.			D D / M M / Y Y Y Y				

Are all insured Indian nationals and Indian residents? Yes ☐ No ☐

DETAILS OF OTHER HEALTH INSURANCE POLICIES IN EXISTENCE

Is any proposer or the person proposed, already insured under a plan with ICICI Lombard GIC Ltd? Yes ☐ No ☐

If yes please indicate below the Policy number(s) (Please mention proposal number in case of pending proposal.)

Insured Name	Policy No. / Proposal No.	Period of Insurance	Sum Insured	Claims lodged during policy period (Yes/No)

DETAILS OF THE INSURANCE PRODUCT/ PLANS

Please tick any of the below mentioned products, ICICI Lombard Complete Health Insurance or Healthcare Plus or both products, as per your health care needs

ICICI Lombard Complete Health Insurance ☐

Tenure	☐ 1 Year ☐ 2 Years	Plan Type	☐ Individual ☐ Floater	Plan Options	☐ 1A ☐ 1C ☐ 2A ☐ 2A+ 1C	☐ 1A + 1C ☐ 2A + 2C	☐ 1A + 2C ☐ 2A + 3C

Plan Details	☐ Individual Health Insurance	☐ Health Secure	☐ Health Secure Plus	☐ Health Protect	☐ Health Protect Plus	☐ Health Smart	☐ Health Smart Plus	☐ iHealth	☐ iHealth Plus

Sum Insured	☐ 1 Lakh	☐ 2 Lakh	☐ 3 Lakh	☐ 4 Lakh	☐ 5 Lakh	☐ 7 Lakh	☐ 10 Lakh	☐ 15 Lakh	☐ 20 Lakh	☐ 30 Lakh	☐ 50 Lakh

Sub - limit	☐ Sublimit A	☐ Sublimit B	☐ Sublimit C	☐ No Sublimit
	Applicable only for 2 lacs sum insured.		Applicable only for 3,4,5 lacs sum insured.	

Add-ons Cover	☐ Hospital Daily Cash (HDC) + Convalescence Benefit (Option 1)	☐ Compassionate Visit + Nursing at Home (Option 3)	☐ *Critical Illness + Donor Expenses + Personal Accident (Option 5) ☐ Insured 1 ☐ Insured 2 ☐ Both	☐ *Critical Illness + Donor Expenses (Option 6) ☐ Insured 1 ☐ Insured 2 ☐ Both

*Critical Illness, Donor Expenses & Personal Accident available only for adults, subject to maximum of 2 adults only upto 60 years of age.
Medical Report Required for person aged 46 years and above and/ or for Sum Insured option above 10lacs.

Healthcare Plus ☐

Tenure		Age Band	No. of Individuals			
☐ 1 Year	☐ 2 Years	☐ 5 - 65# Years	☐ 1	☐ 2	☐ 3	☐ 4

Sum Insured	☐ 5 Lacs; Deductible 2 lacs	☐ 8 lacs; Deductible 3 lacs	☐ 10 lacs; Deductible 4 lacs

Medical report required for person aged 56 years and above. All family members to have same policy tenure and plan.

PAYMENT DETAILS

Payment Option: Cheque ☐ DD ☐ Cheque/ DD Number: ☐☐☐☐☐☐ Dated: D D / M M / Y Y Y Y

Premium Amount: ☐☐☐☐☐☐☐ Amount in words: ______________________

BANK ACCOUNT DETAILS

For direct payment of claims/ refunds in the account, please fill the following:

Bank ______________________ Branch ______________________

MICR ______________________ IFSC* ______________________

Account Type: ☐ Savings ☐ Current ☐ Cash Credit ☐ Overdraft

*Please enclose cancelled cheque along with the Proposal Form for direct payment in the account. In case the cheque doesn't bear a/c holder name or branch IFSC code or both, kindly fill the NEFT mandate form

☐ Yes, I would like to opt for ECS Payment option for Policy Renewal.

I/we hereby declare and undertake that the amount paid by me/us as premium for the aforementioned policy is out of my/our lawful and declared source of income

Signature of the proposer/customer: ______________ Place: ______________ Date: D D / M M / Y Y Y Y

MEDICAL AND LIFESTYLE INFORMATION

SECTION A: Have any of the person proposed to be insured ever suffered from / are suffering from any of the following: Please tick 'YES" for insured wherever applicable and provide details in Section B

	Ye s/ No	Insured 1	Insured 2	Insured 3	Insured 4	Insured 5
1. Hypertension History :	Y N					
a) Duration						
b) Medications						
c) Dosage						
2. Diabetes Mellitus History :						
a) Type I or Type 2	Y N					
b) Duration						
c) Medications						
d) Dosage						

	Yes/ No	Insured No
3. **Heart and Circulatory Conditions/Disorders:** chest pain, angina, high cholesterol/lipids, palpitations, congestive heart failure, coronary artery disease, heart attack, bypass surgery/angioplasty, valve disorder/replacement, pacemaker insertion, rheumatic fever, congenital heart condition, varicose veins, thrombosis, blood disorders etc.?	Y N	1 2 3 4 5
4. **Urinary Conditions/Disorders:** Blood in urine, urinary frequency, painful/difficult urination Kidney and/or Bladder infections, stones of urinary system, renal failure, dialysis or Any Other Kidney/Urinary Tract Or Prostate Disease	Y N	1 2 3 4 5
5. **Musculoskeletal Conditions/Disorders:** Joint/back pain Arthritis, Spondylosis, Joint Replacement Or Any Other Disorder of Muscle/ Bone/ Joint/ ligaments, tendons or discs, gout, herniated disc, amputation/prosthesis	Y N	1 2 3 4 5
6. **Respiratory Conditions/Disorders:** Shortness/difficulty of breath, Tuberculosis, Asthma, Bronchitis, Chronic Obstructive Pulmonary Disease COPD, chronic cough , coughing of blood, etc or any Other Lung / Respiratory Disease	Y N	1 2 3 4 5
7. **Digestive Conditions/Disorders:** Jaundice, chronic diarrhea, intestinal bleeding/problems/polyps, diseases of the pancreas, liver or gall bladder, hepatitis A/B/C/other, jaundice, Cirrhosis, unexplained weight loss or gain, eating disorder or any Other Gastro Intestinal condition	Y N	1 2 3 4 5
8. **Cancer/Tumor -** Benign Or Malignant tumor, Any Growth/Cyst, any Cancer	Y N	1 2 3 4 5
9. **Brain/Nervous System/ Psychiatric Conditions/Disorders:** Loss of consciousness, fainting, dizziness, numbness/tingling, weakness, paralysis, head injury, stroke, migraine headaches or chronic severe headaches, sleep apnea, multiple sclerosis, seizures/epilepsy or any Other Brain/ Nervous System Disease, Mental/Psychiatric disorder	Y N	1 2 3 4 5
10. **Female Reproductive Conditions/Disorders:** Pelvic pain, abnormal, menstrual bleeding abnormal PAP smear, endometriosis, Fibroid, Cyst/ Fibroadenoma, Bleeding Disorder, Pelvic infection Or Any Other Gynecological / Breast cysts/lumps/tumor	Y N	1 2 3 4 5
11. Is any female member pregnant, tested positive with a home pregnancy test, or in the process of adoption or becoming a surrogate?	Y N	1 2 3 4 5
12. **Metabolic and Endocrine Conditions/Disorders:** Adrenal/pituitary disorders, lupus, scleroderma, thyroid disorders, any autoimmune/genetic disorder	Y N	1 2 3 4 5
13. Does the person proposed to be insured suffer from any chronic or long-term medical condition, or have any other disability, abnormality or recurrent illness or injury or unable to perform normal activities?	Y N	1 2 3 4 5
14. Does the person proposed to be insured use tobacco products/cigarettes or drinks alcohol?	Y N	1 2 3 4 5
15. Has any member consulted with or received treatment from any doctor or other health care provider for any other condition or symptom(s)/undergone any hospitalization/illness/surgery/ currently taking medication(s) for any condition or medical procedures (including diagnostic testing)	Y N	1 2 3 4 5
16. Have you or any of the persons proposed for Insurance been diagnosed with or undergone surgery for any of the following Critical Illnesses, prior to proposing for this cover - Cancer, Heart Attack, Coronory Artery, Bypass Graft, Heart Valve Replacement/ Repair, Coma, Kidney Failure, Stroke, any Transplant, Paralysis, Multiple Sclerosis, Motor Neurone Disease	Y N	1 2 3 4 5

SECTION B: Name and details of Illness / Medicine / Test / Surgery / Diopter grade (for questions answered as yes in SECTION A above)	Date of Last Consultation	Doctor's Name	Hospital Name & Phone No.
Insured 1 :			
Insured 2 :			
Insured 3 :			
Insured 4 :			
Insured 5 :			

IMPORTANT NOTES

1. The information that you give to us on this proposal form or in any supplementary Information form or documentation supplied by you or on your behalf will influence our decision to offer insurance and the terms upon which to offer it. Further, any policy we issue will be based on what you have communicated to us. It is therefore important that your answer are complete and accurate in all respect.
2. The question in this proposal are indicative rather then exhaustive. You must provide us with all information relevant to the risk to be insured, even if it is not the subject of a question in this proposal. If you are in any doubt as to what information should be given, you should liaise with your insurance advisor/ company.
3. Acceptance of your proposal would be subject to receipt of complete medical reports(wherever applicable), medical underwriting and realization of full premium amount by the company and the insurance coverage will commence from the date of underwriting by the company.
4. The list of exclusions/ inclusions and other policy details are indicative, for complete list and comprehensive details kindly refer policy wordings.

ELECTRONIC CLEARING SERVICE (Debit Clearing) MANDATE FORM

Proposal No. T / 022013-14 **Policy:** ☐ 4128 (ILCHI) ☐ 4113 (HCP)

To,

ICICI Lombard General Insurance Company Ltd., ICICI Lombard House, 414, Veer Savarkar Marg, Near Siddhi Vinayak Temple, Prabhadevi, Mumbai 400 025.

Ref : Authorization of Customer to remit funds/payments to ICICI Bank Ltd through Electronic Clearing Service

Customer Information:

a. Account Holder(s) Name (As appearing in the Bank Records):

b. Bank Name: c. Bank Branch Name:

d. Address: e. Branch City:

f. Account Type: Savings ☐ Current ☐ Cash Credit ☐ Overdraft ☐ g. Account No.:

h. Ledger No./ Ledger Folio No.: i. 9 Digit MICR Code :

Declaration:

I wish to avail the Electronic clearing facility and hereby express my unconditional consent to debit premium for my Health insurance policy applied vide proposal form no. xxxxxxxxxxx through participation in Electronic Clearing System (ECS). I, understand and agree that premium amount to be debited from my account may vary due to change in age bracket of the senior most member insured under the policy, claims history in expiring policy, change in applicable premium rates by the insurer, taxes and other statutory levies as may be applicable from time to time.

(Please refer to sales brochure for approximate premium details due to change in age applicable at the time of renewal)

I, hereby declare that the particulars given are correct and complete. I understand and accept that the transaction will be effected on the due date as opted by me in this form subject to the payment of premium on the policy (provided the day is a working day). If the transaction is delayed or not effective at all for reasons of incomplete or incorrect information, I/we would not hold the user institution responsible. I/We have read all the terms and conditions as are applicable for availing of this ECS Debit service from/through the user institution and agree to discharge the responsibility expected of me/us as a participant under the scheme.

I/We also hereby authorize representative of ICICI Lombard General Insurance Company Ltd. carrying this ECS Debit Mandate Form to get it verified and executed by my/our Bank.

STATUTORY WARNING

PROHIBITION OF REBATES

(Under Section 41 of 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 five hundred rupees.

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 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 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.

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/proposal 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 doctor or from a hospital who at any time has attended on the life to be insured/proposed 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.

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 Government and /or Regulatory authority.

Signature of the proposer/customer: _____ Place: _____ Date: D D / M M / Y Y Y Y

ICICI Lombard Health Insurance

Mailing Address: ICICI Lombard General Insurance Company Limited, Interface Building No.11, 401/402 4th Floor, New Link Road Malad (W), Mumbai - 400064.
Registered Address: ICICI Lombard General Insurance Company Limited, ICICI Lombard House, 414, Veer Savarkar Marg, Near Siddhi Vinayak Temple, Prabhadevi, Mumbai 400 025.
Visit us at www.icicilombard.com • Mail us at customersupport@icicilombard.com
Now One Number for all your Insurance needs 1800 2666 (Toll Free also accessible from your mobile) SMS Facility "HEALTHCLAIM" to 575758

014174PF/SC

I, hereby authorize ICICI Lombard General Insurance Co. Ltd. and their authorized service providers, to enable the ECS facility for my premium payments and in the instance of ECS debit dishonor, to re-debit my account with the mentioned bank to recover the premium payable.

Primary Account Holder's Signature (If different from Policy Holder)

Policy Holder's Signature

Joint Account Holder's Signature 1

Joint Account Holder's Signature 2

FOR OFFICE USE ONLY

Customer ID:

For Use by Customer/Account Holder's Bank :

Proposal No. T / 022013-14 **Policy:** 4128 (ILCHI) 4113 (HCP)

We hereby certify that the particulars of the customers furnished above are correct as per our records, and we hereby declare that a copy of this mandate form, duly complete and signed, has been submitted to us

Bank Stamp: _____ Signature of Authorized Official of the Bank _____

Name: Branch:

Designation: Date:

Disclaimer:

- Subject to change in service tax rates / re-instatement charges and as per customer's request. ICICI Lombard GIC Ltd. shall debit the customer's bank account if the customer's policy and the ECS mandate are In Force and until the customer gives a written request for cancellation of ECS.
- Request for cancellation of ECS facility has to be provided 15 days prior to the due date or the same would be effective from the next premium due date.
- Requests for payment mode to change to ECS has to be provided 30 days prior to the due date or the same would be effective from the next premium due date.
- Data provided by the customer in the cheque copy and the proposal form may be used by the Company to complete the ECS mandate in case required information has not been filled.