Liberty General Insurance Ltd.
Unit 1501&1502, 15th Floor, Tower 2, One International Center,
Senapati Bapat Marg, Prabhadevi, Mumbai – 400013,
Phone: +91 226700 1313 Fax: +91 226700 1606
IRDAI of India Reg. No.150, CIN: U66000MH2010PLC269656

URN - LH002V022021

Group Hospi-Cash Connect Policy
Proposal Form

The acceptance of the proposal is subject to receipt of the total premium and realization of payment will be as per the policy terms and conditions. Kindly fill the form completely in CAPITAL LETTERS to help us to serve you better. The Company is under no obligation to accept this Proposal. Receipt of this Proposal by the Company along with the premium payment & medical reports, if applicable, does not tantamount to the acceptance of the Proposal by the Company and does not result in a concluded contract of insurance. Coverage is as per the terms and conditions of our Standard Policy Wordings. The Policy shall become voidable at the option of the Insurer, in the event of any untrue or incorrect statement, misrepresentation, non-description, failure to disclose or suppression of any material facts in response to the questions in the proposal form or on non-disclosure of any material particular.

GUIDELINES TO FILL THE FORM	GOING GREEN JUST GOT EASIER!!! SAVE PAPER. SAVE TREES.
1. Please answer all the questions completely. If a particular question is not applicable to you, please mark that question as not applicable "N/A". 2. Please attach extra sheets wherever the space is insufficient to provide the additional underwriting information. Put a (✓) mark wherever applicable. 3. Kindly contact the Company's Office or Intermediary for any doubts or clarifications on the Proposal Form.	How would you want the policy pack to be received? **Electronic/Soft Copy ☐ Physical/Hard copy ☐**

1. Company/ Proposer Details

Company/Proposer Name:
Address:
Industry Type:
Contact Person:
Position:
Designated Email Address: **Fax:**
Contact No/Mobile No: **E-mail ID:**
PAN No / Form 60: **CKYC No:**
Nationality:
If Non Indian Please specify Country Name:_____

2. Proposal Details

Business Type: **New ☐** **Own Renewal ☐** **Other Renewal ☐**

Policy Type: Individual ☐

Sum Insured: _____

Proposed Policy Period: From d d m m y y y y **To** d d m m y y y y

No of Primary Members: **No of Dependents:** **Total Group Size:**

Proposed Covers:

A. Basic Cover	Please tick (✓) the Proposed cover	Please mention the Limits Proposed
Daily Hospitalization Cash Benefit (DHC) **OR**		
Daily Hospital Cash (DHC)- Only Accidents Benefit		
B. Choose and Pick covers		
Double Accident Benefit (DAB)- in case of Hospitalization more than 3 days		
Double ICU Benefit (DIB) -Sickness		
Double ICU Benefit (DIB) -Accident		
Recovery Benefit		*Upto __ times of DHC limit

Convalescence benefit		*Upto __ times of DHC limit
Special care on Minor Surgeries		*Upto __ times of DHC limit
Special care on Major Surgeries		*Upto __ times of DHC limit
Restore Benefit		
Double Critical Illness Benefit (DCI)-Listed Critical Illnesses		
Day care Procedure Cash- Listed Procedures		
Wellness Program		
Special Limit		
Special Care		**Available for the member upto 60 Years of age**

***Can select maximum upto 15 times of DHC limit.**

3. Proposed Insured(s) Details

Sr. No	Emp Code	Employee Name	Dependent Name	Relationship	DOB	DOJ	Pre Existing Disease	Designation	SI	Nationality

If Non Indian please specify Country Name	Permanent Address	Present Address	Mobile No	E.mail ID	ABHA No	Ac No	IFSC	Bank Name	Branch	Do any of the proposed insured persons have / had any disability ?	Name of Disability	Percentage of disability

Nominee Name & Relationship	Mobile No	Email ID	Specify % of claim	Permanent Address	Present Address	Nominee in case of Minor Details of Authorized person	Ac No	IFSC	Bank Name	Branch

(Individual member details to be furnished by way of Annexure I- A provided hereunder)

4. Previous/Existing Insurance Details (if any)

Year	Premium	Claim Details								Group Size
		Claims Paid		Claims O/s		Claims Rejected		Claims Closed		
		No.	Amount	No.	Amount	No.	Amount	No.	Amount	
Year 1										
Year 2										
Year 3										
Year 4										
Year 5										

5. Previous Policy Terms and Conditions

_____
_____
_____

6. Additional Information (If any)

7. Payment details

Instrument type (Cash/Cheque/DD/Others)	Name of the premium payer	Bank Name	Cheque Date	Amount in Rs

Please make an A/C Payee Cheque / DD / Pay Order in favour of 'Liberty General Insurance Limited' only

For NEFT Payments, please fill the Bank details mentioned below:

Bank Name																	
Branch																	
City																	
Account No																	
IFSC Code																	

Account Type: Savings ☐ **Current** ☐

AML Details:

Are you or any of your relatives a Politically Exposed Person? Yes ☐ No ☐

If yes, please provide details:

_____

Politically Exposed Persons (PEP) are individuals who are or have been entrusted with prominent public functions i.e., Heads/Ministers of central or state government, senior politicians, senior government, judicial or military officials, senior executives of government companies, important party officials.

Please provide Permanent Account Number (PAN) if premium amount exceeds Rs. 1 Lac _____

☐ I/We hereby declare that the premium for the said policy is paid out of the legally declared and assessed sources of my/our income OR

☐ I/we hereby declare that the premium is paid from the Bank Account of Mr. /Ms._____ the payment is allowed under the Income Tax Act 1961, and there is insurable interest with the payee.

☐ I/ We hereby confirm that all premiums are paid from bonafide sources and no premium have been paid out of the proceeds of crime related to any of the offence listed in Prevention of Money Laundering Act 2002 and its subsequent amendments thereof. I/We understand that the company has the right to call for the documents to establish source of funds. The Company has the right to cancel the insurance contract in case I am/We have been found guilty by any competent court of law under any of the statues, directly/ indirectly governing the prevention of Money Laundering in India.

Statutory Warning: Prohibition of Rebates as per Section 41 of the Insurance Act 1938 (4 of 1938)`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 prospectus or tables of the insurer'. Violations of Section 41 of the Insurance Act 1938 r/w Insurance Laws (Amendment) Act, 2015, shall be - Any person making default in complying with the provisions of this section shall be liable for a penalty which may extend to ten lakhs.

8. 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 / 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 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 the purpose of underwriting the proposal and / or claim settlement.
- ☐ I/We authorise 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."
- ☐ We understand that the Master Cover shall become void at the Company's option, in the event of any untrue or incorrect statement, misrepresentation, misdeclaration, non-description or non-disclosure of any material fact in the Proposal form/personal statement, declaration and corresponding documents or any material information having been withheld by us or anyone acting on our behalf.
- ☐ We consent to receive information from the Company through physical, electronic or telecommunication means from time to time.
- ☐ I hereby declare that the above statements, answers and/or particulars given by me in this proposal form are true and complete in all respects to the best of my knowledge and that I am authorized to propose on behalf of the Master Cover Holder.
- ☐ I/We hereby declare that, in case any of the statement provided hereinabove is found to be false or misrepresentation, the Company at its option may terminate the Insurance Policy, forfeiting the premium paid by me/us under the said Policy. The Company may also initiate such action against me/us as it may deem appropriate in the event of me/us furnishing any false statement or in case of any misrepresentation by me/us in connection with obtaining the insurance policy from the Company.
- ☐ I/We hereby give voluntary consent to Liberty General Insurance Limited/Company to process/share my/our personal information and data provided in this form with its group companies or any other person/ Service Provider of Company in connection with the Insurance Policy/ claims made there under or otherwise, including for providing other products of the Company that may be of interest to me/us, to be used in accordance with their respective privacy policies.
- ☐ I/We hereby provide my/our consent in accordance with Aadhar Act. 2016 and Prevention of Money Laundering Act, 2002 including amendments thereafter therein and Rules/Regulations made thereunder including amendments thereafter for validating/authenticating my/our Aadhar details and updating the same in all my polices held with the company.
- ☐ I/we hereby give my/our consent to the Company to verify and obtain my/our identity/address proof through CERSAI records, UIDAI or National Securities Depository Limited or such other authorities as may provide such services from time to time for the purpose of compliance with prevention of money laundering act read with anti-money laundering guidelines issued by IRDAI.
- ☐ I understand if a physical policy pack is required, I may request the insurance company at the call center number or email id, or address mentioned on the company website to issue the same at the registered address mentioned above.
- ☐ I/We hereby provide consent to share my/our medical records with the insurer or TPA and encourage creation of ABHA ID for all Policy holders at www.healthid.ndhm.gov.in and may notify in case customer wishes to the same with Insurer.
- ☐ I hereby give my consent to receive phone calls, SMS/E mail on the below mentioned registered number/ E mail address from / on behalf of Liberty General Insurance with respect to my insurance policy/regarding servicing of insurance policies/enhancing insurance awareness/ notifying about the status of Claim etc
- ☐ I/We hereby extend my/our consent to the Company for sharing my/our personal data with Liberty Insurance Group entities/affiliates for the specific purpose of claim settlement quality, data analysis purpose, reinsurance related services (please strike this clause in case you do not wish to disclose the personal data).
- ☐ I agree to receive service-related information from LGI and its service providers, through electronic and telecom modes including WhatsApp and further understand that no unsolicited information will be sent to me. The information/ data provided by me through this Proposal Form, to LGI and / or LGI authorized personnel / agency shall be stored by LGI, throughout the term of my relationship with LGI and used for the purpose relating to my proposal for insurance cover and/or servicing policies issued in my favor, whether by LGI or its authorized partners. I also understand that the said storage is necessary for my consumption of the services and consent to not hold LGI and / or its authorized partners / agency / personnel liable for legal utilization of the submitted information / data.
- ☐ I hereby consent to the collection, use and disclosure of my personal information for the assessment of this application and in accordance with Liberty General Insurance Privacy Notice ('Privacy Notice') available at https://www.libertyinsurance.in/ which I have read, understood and agree to the contents of the Privacy Notice.

Important Note:

I hereby give my/our consent to Liberty General Insurance to collect, use, process, and share my/our personal information for policy servicing, claim settlement quality, and data analysis purpose, which may be carried out by an empanelled third-party vendor
Yes☐ No☐

Date:_____ **Signature of Proposer /Authorized signatory**

DECLARATION BY INTERMEDIARY/PROPOSER

I, the intermediary/ proposer hereby declare and confirm that I have explained/understood the features, terms and conditions of the policy and questions contained in the proposal form. I have also explained/understood that the answers to the questions contained in the proposal form, forms the basis of the contract of insurance. If any information/statement given in proposal is found to be untrue, the policy shall be treated as void ab intio and the premium paid shall be forfeited to the Company.

IMD name: **Proposer name:**
IMD Code:
IMD Sign*: **Proposer sign:**

*Stamp in case of Company

DECLARATION IN CASE THE PROPOSER IS ILLITERATE OR PROPOSAL FORM IS IN LANGUAGE OTHER THAN UNDERSTOOD BY PROPOSER

(To be signed by person who has explained the contents of the proposal form to the Proposer)

I, the declarant/proposer hereby declare and confirm that I have explained/understood the contents of the proposal form in _____ language understood by proposer/me and proposer have affixed his/her signature/thumb impression on the proposal form only after understanding the contents thereof.

Declarant's Name: **Proposer Name:**

Signature: **Signature/thumb impression**

9. Acknowledgement

ApplicationNo: | | | | | | | | | | | **Date:** | d | d | m | m | y | y | y | y |

We acknowledge with thanks the receipt of your application and amount by Cash/Cheque/Demand Draft/Others _____ of the amount of Rs. _____ dated _____ drawn on _____.

The Company will have no liability until the proposal is accepted by the Company and communicated so to the proposer and on receipt of full premium against the proposal.

Please note the following:

1. This acknowledgment letter confirms only receipt of premium towards insurance policy. Issuance of this receipt neither confirms assumption of risk nor guarantees issuance of policy.
2. Assumption of risk is subject to realization of full premium amount and acceptance of risk in form of issuance of an insurance policy as per underwriting policy of the Company.
3. In case premium is not realized by the company due to any reason, Company shall not be on cover and contract of insurance shall be treated as void ab-initio.
4. In the event of any refund of premium or claim amount being payable under the policy, the same shall be paid directly to the Proposer/Insured/Nominee (as applicable), as per the details mentioned in duly filled proposal form.

Signature of the receiver & office Seal:

10. For Office use only

Intermediary Name:	**Intermediary Code:**	
Sales Manager Name:	**Sales Manager Code:**	

Annexure I - A

Member Data

Sr. No	Emp Code	Employee Name	Dependent Name	Relationship	DOB	DOJ	Pre Existing Disease	Designation	SI	Nationality

If Non Indian please specify Country Name	Permanent Address	Present Address	Mobile No	E.mail ID	ABHA No	Ac No	IFSC	Bank Name	Branch	Do any of the proposed insured persons have / had any disability ?	Name of Disability	Percentage of disability

Nominee Name & Relationship	Mobile No	Email ID	Specify % of claim	Permanent Address	Present Address	Nominee in case of Minor Details of Authorized person	Ac No	IFSC	Bank Name	Branch

Note : In case of additional member/s, please share all above detail in a separate document.