Liberty General Insurance ™

URN: LH015V12023

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.	**CONSENT FOR ELECTRONIC DISPATCH OF POLICY PACK** I want to Save Trees and Contribute to the Environment. Therefore, I hereby authorize Liberty General Insurance Limited to provide me an Electronic Policy Pack. I understand, subscribing to Electronic Policy Pack means, the policy pack will only be sent to my registered email id and no physical policy pack will be sent across.

Liberty Surro Assure
Proposal Form

Liberty Surro Assure product is specially designed for providing insurance cover to Oocyte Donor and Surrogate Mother as per The Surrogacy (Regulation) Act, 2021 and The Assisted Reproductive Technology (Regulation) Act, 2021 and is subject to any change, modification and amendment as per the above referred Acts.

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 submission 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.

1. Proposer Details

A.   PROPOSER (SELF)*

Proposer(Mr/Mrs/Ms)			
	First Name	Middle Name	Last Name

Address:			
		City/Town:	
District:		State:	
Pin Code:		Mobile:	
Telephone:		E Mail:	
Date of Birth:		Gender:	
Nationality:		Marital Status:	
Annual Income:		Educational Qualification:	

Profession: Salaried   Self Employed   Others   Details: _____

Liberty Employee No. (if applicable): _____

B.   PROPOSER (SPOUSE)

Proposer(Mr/Mrs/Ms)			
	First Name	Middle Name	Last Name
Date of Birth:		Gender:	

Confirmation for Issuance of e-Insurance Policy:

E Insurance account no._____ . I would like to open E insurance account with _____ Insurance Repository.

*PAN number:

GSTIN:

2. Plan Details

Plan*	Plan 1 - Oocyte Donor	Plan 2 -Surrogate Mother
Policy Period	12 months	36 months
Sum Insured (INR)	INR 2 Lakhs	INR 3 Lakhs
Policy Type	Individual Sum Insured basis	Individual Sum Insured basis
Who are covered (Relationship with respect to the Proposer)	Oocyte Donor	Surrogate Mother

*The Policyholder/Insured Person can opt either Plan 1 or Plan 2 under the product.

Business Type: New   **Policy Type:** Individual

Plan: Oocyte Donor   OR   Surrogate Mother

Proposed Policy Period: From   To

D	d	m	M	y	Y	y	Y		d	d	m	m	y	Y	y	y

3. Proposed Insured(s) Details

	Proposed Insured I
Name	
Relationship with proposer	
Gender	Female
Date of Birth	
Height	
Weight	
Profession	Salaried Self Employed Others _____ _____
First Policy Inception Date of any other Insurer: (dd-mm-yyyy)	Surrogacy Clinic Registration No.
Certificate details of Surrogate Mother	
Certificate details of Intending Couple/Woman	
ABHA ID	

If ABHA ID is not available, we urge you to visit abdm.gov.in for creation of ABHA ID and inform the same to us once created.

4. Medical & Lifestyle Information

Medical History: Please tick the relevant disease and provide details.

In case of no medical history please mention 'No' against the respective column of the proposed Insured member

Section A: Has the proposed insured ever suffered from/currently suffering from any of the following	Proposed Insured I
Hypertension, Chest Pain or any other cardiac disorder	
Tuberculosis, asthma or any other lung/respiratory disorder	
Kidney stone/failure, urinary tract/prostrate disorder	
Dizziness/stroke/paralysis/epilepsy or any brain/nervous system disorder	
Diabetes/thyroid or any hormonal disorder	
Tumor – benign/malignant, any cyst/ulcer/growth	
Arthritis/spondylosis or any other bone/muscle/joint disorder	
Disease of the nose/throat/ear/eye/dental	
Anaemia/leukemia or any other blood disorder	
HIV/AIDS/any sexually transmitted disorder	
Psychiatric/mental illness or sleep disorders	
DUB, Fibroid, Cyst, Fibroadenoma or any other Gynaecological disorder, menopause & GPAL History	

Section B: Has the proposed insured persons	
Been addicted to alcohol/narcotics/habit forming drugs or under any detoxication therapy	
Been under any regular medication (self/prescribed including hormones or OC Pills)	
Undertaken any lab tests like blood/urine/stool or any imaging tests like sonography/MRI/CT/X-Rays in the last 5 yrs	
Undertaken any surgery or advised any surgery in the last 10 yrs or is a surgery pending?	
Suffered from any other illness/disease/accident/injury	
Is any of the proposed insured pregnant? If yes please specify expected date of delivery	
Any complaint of diabetes, hypertension or any complication during current or earlier pregnancy?	
Section C: Does person proposed to be insured consume	
Alcohol (Please mention quantity per week)	
Smoke (Please mention quantity per week)	
Pan Masala/Gutka (Please mention quantity per week)	
Others (Please mention name & quantity per week)	

If answer to the above questions is Yes, please elaborate:

Sr. No	Name of the Proposed member	Name of illness/injury suffering from or suffered in the past	Date of first diagnosed/detected	Treatment/medication received/ receiving	Details of Hospitalization (If any)	Is it fully cured
1						

Please provide details of hereditary medical history, if any:

_____

_____

_____

5. Additional Information (if any)

6. Previous/Existing Insurance Details (if any)

Is the person proposed for insurance, already insured under or proposed for a health insurance policy from any other insurance company? If yes, please indicate below the Policy/ Application number(s) (Please mention application number in case of pending proposal)

Policy No/Appl no	Insured Name	Insurance Company	From (date)								To (date)								Sum Insured	*Claim Details (if any)
			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		

*
Please provide claim details:_____

7. Payment details

Instrument type (Cash/Cheque/DD/Others)	Name of the premium payor	Installment facility (Yes/No)	Bank Name	Cheque Date	Amount in Rs
				DD/MM/YYYY	

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:

Liberty Surro Assure Policy -Proposal Form (Effective from 30.09.2024)
UIN- **LIBHLIP24417V012324**

Liberty General Insurance Limited
Unit 1501&1502, 15th Floor, Tower 2, One International Center,
Senapati Bapat Marg, Prabhadevi, Mumbai – 400013
Phone: +91 22 6700 1313 Fax: +91 22 6700 1606
Email: care@libertyinsurance.in
IRDA of India registration number: 150 ● CIN: U66000MH2010PLC209656

Bank Details of the Proposed Insured:

Bank Name:																									
Branch:																									
City:																									
Account No:																									
IFSC Code:																									

Account Type: Savings   Current

Bima ASBA

☐ "I here by accord my consent to authorise 'Liberty General Insurance Limited' to block the applicable premium payable for the aforesaid insurance policy under the BIMA ASBA facility and debit the same from my bank account upon acceptance of this proposal. In case the proposal is not accepted, I accord my consent to debit only the expenses incurred towards medical examination, if any, and unblock the balance amount. If Amount of initial premium blocked is less than the premium to be collected, then I agree to pay the differential premium amount through payment link shared by Insurer"

UPI ID	UPI No. (Mobile No.)	Bank Name	Amount in Rs

AML Details:

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

If yes, please provide details: _____

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.

9. Checklist of Documents

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

1. ID Proof: Passport / PAN Card / Voter's Identity Card /   Driving License / National Identity Number
2. Residence Proof: Telephone Bill / Electricity Bill / Bank Account Statement / Ration Card
3. Age Proof: Any proof of age
4. Intending Couple or Intending Woman as applicable to provide certificate of recommendation issued as per provision of the Surrogacy (Regulation) Act, 2021
5. Certificate of medical and psychological fitness for surrogacy and surrogacy procedures from a registered medical practitioner, for Surrogate Mother
6. Copy of Registration Certificate of Surrogacy Clinic

Important Note:

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

Signature of the receiver and a co seal

10. Declaration

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 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 insurer and that the policy will come into force only after full payment of the premium chargeable.

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.

I declare that I 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 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."

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.

_____   _____
Date   **Signature of Proposer**

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.

Nominee Declaration from proposed Insured Person

I, the undersigned hereby nominate <Name>, <Relationship> for the purpose of payment of claims under the policy in the event of my death. Any change of nomination shall be communicated to the company in writing.

Date: **Proposed Insured Person Signature:**
Place: **Proposed Insured Person Name:**

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: Proposer sign:

IMD 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

11. For Office Use Only

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

12. 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:

Liberty General Insurance Limited
Registered Office: 10th Floor, Tower A, Peninsula Business Park, Lower Parel, Mumbai