Liberty General Insurance Limited,
Unit 1501 & 1502, 15th Floor, Tower 2, One International Center,
Senapati Bapat Marg, Prabhadevi, Mumbai - 400 013.
Phone: +91 22 6700 1313 Fax: +91 22 6700 1606
Email: care@libertyinsurance.in
IRDA registration number: 150 ● CIN: U66000MH2010PLC209656

CORONA RAKSHAK POLICY, LIBERTY GENERAL INSURANCE LIMITED.
PROPOSAL FORM

Proposal No.: | | | | | | | | | | | | | |

URN: LH013V12020

GUIDELINES TO FILL THE FORM

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.

GOING GREEN JUST GOT EASIER!!! SAVE PAPER. SAVE TREES.
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 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.

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.

1. Proposer Details

Last Name | First Name | Middle Name

Proposer (Mr / Mrs / Ms) :			
Address :			
City/Town :		State :	
District :		Pin Code :	
Telephone :		Mobile :	
E-mail :			

Residential Address of the propoesed member (s) in the Policy: As above / Provide below if different:

Address :			
City/Town :		State :	
District :		Pin Code :	
Telephone :		Mobile :	
Nationality:		Marital Status:	
Annual Income:		Educational Qualification:	

Confirmation for Issuance of e-Insurance Policy:
E Insurance account no.:_____ I would like to open E insurance account with_____.Insurance Repository.

PAN Number:			
Aadhar Number:		GSTIN:	

2. Proposal Details

Business Type: New ☐ Policy Tenure: 3 ½ Months ☐ 6 ½ Months ☐ 9 ½ Months ☐

Policy Type: Individiual

Sum Insured: INR | | | | | | |

If Yes, Monthly ☐ Quarterly ☐ Half-yearly ☐

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

Proposed Insured(s) Details:

	Proposed Insured I	Proposed Insured II	Proposed Insured III	Proposed Insured IV	Proposed Insured V
Name					
Relationship with proposer	Relationship with proposer	Relationship with Insured I	Relationship with Insured I	Relationship with Insured I	Relationship with Insured I
Gender					
Date of Birth	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
Height (cm)					
Weight (Kg)					
Occupation	<<Please mention explicity if belongs to Healthcare worker/ Doctor>>				
Nominee Name					
Relationship of Nominee					
Nominee Address					
ABHA Id :					

'If ABHA ID is not available, we urge you to visit https://abdm.gov.in/ for creation of ABHA ID and inform the same to us once created.'
Note : In case of additional member/s, please share all above detail in a separate document.

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3. Medical & Lifestyle Information

Medical History: Please answer the below mentioned questions in Yes (Y)/No (N). If the answer to any of the questions is Yes, please give details in the table given below. Alternatively attach a separate sheet of paper.

1. Have you or any member of your family traveled overseas in last 3 months — Yes ☐ No ☐
2. Have you or any member of your family been diagnosed with Corona Virus — Yes ☐ No ☐
3. If YES, please provide the details of doctor and treatment duration — Yes ☐ No ☐
4. Do you have any symptoms of Cold/Cough etc. currently — Yes ☐ No ☐

Section A: Have any of the proposed insured ever suffered from/currently suffering from any of the following

Habits	Proposed Insured I	Proposed Insured II	Proposed Insured III	Proposed Insured IV
Hypertension, Chest Pain or any other cardiac disorder				
Tuberculosis, asthma or any other lung/resporatory disorder				
Tumor - benign/ malignant, any cyst / ulcer / growth				
Kidney stone/ failure, urinary tract/ prostrate disorder				
Dizziness/stroke/paralysis/epilepsy or any brain/nervous system disorder				
Diabetes/ thyroid or any hormonal disorder				
Arthritis/spondylosis or any other bone/muscle/ joint disorder				
Anaemia / leukemia or any other blood disorder				
HIV/AIDS any sexually transmitted disorder				
Psychiatric / mentall illness or sleep disorders				
DUB, Fibroid, Cyst, Fibroadenoma or any other Gynaecological disorder, menopause & GPAL History (to be filled for female lives only)				

Section B: Have any of 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 OCPills)				
Undertaken any lab test 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 compilation during current or earlier pregnancy?				

Section C: Does any person proposed to be insured consume

Hard Liquor/ Wine/ Beer (Please mention quantity per week)				
Pan Masala / Gutka (Please mention quantity per day)				
Smoking (Please mention quantity per day)				
Others (Please mention quantity per day)				

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						
2						
3						
4						
5						

Please provide details of hereditary medical history, if any: _____

4. Additional Information (If any)

_____

_____

_____

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5. Previous/Existing Insurance Details (if any)

Is any of the member proposed, already insured under or proposed for a health Insurance policy for in-patient hospitalization with Liberty General Insurance Limited or any company? if yes, please indicate below the Policy/ Application number(s) (Please mention application number in case of pending proposal)

Since when are you continuously insured? (Date of first inception policy) d d m m y y y y

Policy No/ Appl no	Insured Name	Insurance Company	From (date)	To (date)	Sum Insured	Cumulative Bonus if any earned	*Claim (Yes/ No)
			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			
			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: _____

6. 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 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.

7. 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

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.

8. 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/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 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 declare that I/we consent to the Company seeking medical information from any doctor or hospital who/which at anytime has attended on the person to be in 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/our proposal including the medical records of the insured/proposer for the sole purpose of proposal underwriting and / or claims settlement and with any Governmental and / or Regulatory authority.

Ayushman Bharat Health Account (ABHA) Declaration : I/We provide my/ our consent to access my/ our (all insured) medical and personal records/ details, as are available in my/ our Ayushman Bharat Health Account (ABHA) and share the same with Third Party Administrators, Reinsurer (if applicable), Service Provider/s of Company and/or with any Governmental and/or Regulatory authority for the sole purposes of underwriting my/ our proposal and/ or for checking the authenticity of claims lodged by me/ us and/ or to comply with the applicable Law/ Regulations.

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.

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Ayushman Bharat Health Account (ABHA) Declaration : I/We provide my/ our consent to access my/ our (all insured) medical and personal records/ details, as are available in my/ our Ayushman Bharat Health Account (ABHA) and share the same with Third Party Administrators, Reinsurer (if applicable), Service Provider/s of Company and/or with any Governmental and/or Regulatory authority for the sole purposes of underwriting my/ our proposal and/ or for checking the authenticity of claims lodged by me/ us and/ or to comply with the applicable Law/ Regulations.

Date **Signature of Proposer**

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 question 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 abintio 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**

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, as amended, 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.

9. FOR OFFICE USE ONLY

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

10. RECEIPT OF ACKNOWLEDGEMENT

Application No: | | | | | | | | | | | **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

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