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 | Email: care@libertyinsurance.in
IRDA of India registration number: 150 | CIN: U66000MH2010PLC209656

Liberty General Insurance™

URN:LHCS16V12024

GUIDELINES TO FILL THE FORM	GOING GREEN JUST GOT EASIER!!! SAVE PAPER. SAVE TREES.
1. 2. Please answer all the questions completely. If a particular question is not applicable to you please mark that question as not applicable "N/A". 3. Please attach extra sheets wherever the space is insufficient to provide the additional underwriting information. Put a (✓) mark wherever applicable. 4. 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 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.

HEALTH CONNECT SUPRA 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.

1. Proposer Details

Proposer(Mr/Mrs/Ms)			
	Last Name	**First Name**	**Middle Name**
Address:			
		City/Town	
District:		**State**	
Pin Code:		**Mobile**	
Telephone:		**E Mail**	

Nationality: _____ **Marital Status:** _____ **Annual Income:** _____ **Educational Qualification:** _____

2. Proposal Details

Business Type: **New** **Renewal** **Rollover** **Policy Tenure:** 1 Yr 2 Yrs

Policy Type: Individual Family Floater **Installment of Premium: 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

Basic Sum Insured (Lakhs): INR _____

Plan: Essential Optimum Optimum Plus
Employee No. (if applicable) _____

UIN- LIBHLIP25035V042425

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Cover Proposed :

	Proposed Insured I	Proposed Insured II	Proposed Insured III	Proposed Insured IV	Proposed Insured V
Name					
Relationship with proposer					
Gender					
Date of Birth					
Height (cm)					
Weight (Kg)					
Occupation					
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)**					
Plan Details: Applicable for Individual Sum Insured Proposal/s					
Plan	Top Up Super Top Up	Top Up Super Top Up	Top Up Super Top Up	Top Up Super Top Up	Top Up Super Top Up
Option	Option I Option II Option III	Option I Option II Option III	Option I Option II Option III	Option I Option II Option III	Option I Option II Option III
Sum Insured(In Lakhs)					
Deductible (In Lakhs)					
Optional Cover(s)	Reload of Sum Insured World-wide coverage Wellness & Assistance Program	Reload of Sum Insured World-wide coverage Wellness & Assistance Program	Reload of Sum Insured World-wide coverage Wellness & Assistance Program	Reload of Sum Insured World-wide coverage Wellness & Assistance Program	Reload of Sum Insured World-wide coverage Wellness & Assistance Program
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)**					
World-wide coverage: Available for Super Top up Plan ONLY					
Plan Details: Applicable for Family Floater Proposal/s					
Plan	Top Up Super Top Up				

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abdm.gov.in for creation of ABHA ID and inform the same to us once created)					
World-wide coverage: Available for Super Top up Plan ONLY					
Plan Details: Applicable for Family Floater Proposal/s					
Plan	Top Up Super Top Up				
Option	Option I Option II Option III				
Sum Insured (In Lakhs)					
Deductible (In Lakhs)					
Optional Cover(s)	Reload of Sum Insured World-wide coverage Wellness & Assistance Program				
Nominee Name					
Relationship of Nominee					
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)**					
Nominee Address					

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

4. 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. Does any person, proposed to be insured, suffered from/ suffering from any disease/illness /Injury - Yes No
2. Does any person, proposed to be insured, suffer from or have been treated for any heart related ailment/blood pressure/Diabetes/Cancer? Yes No
3. Does any person, proposed to be insured, suffer from Paralysis/Asthma/Epilepsy? Yes No
4. Is any person, proposed to be insured, receiving any treatment/medication or have in the past received treatment or undergone surgeries for any medical condition/disability? Yes No
5. Does any person, proposed to be insured consume Alcohol/ Smoke/ Pan masala/ others - Yes No

Please provide details of hereditary medical history, if any:

_____

_____

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						

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5. Additional Information (If any)

_____
_____
_____
_____

6. Previous/Existing Insurance Details (if any)

Is the proposer or the persons proposed, already insured under or proposed for a health insurance policy for in-patient hospitalisation with Liberty General Insurance Limited or any other insurance 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? Please specify the Inception Date of the first Indemnity Health Insurance Policy
_____

Do you want Us to consider these details for Portability? Yes No

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			

Please provide claim details _____

8. 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**

Bima ASBA

☐ "I hereby 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: _____--

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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

For Portability cases

1. Photocopies of previous policies and endorsements
2. Portability Form
3. Renewal Notice with claims details.

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.

10. 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 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/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 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."

I/We hereby provide my/our consent in accordance with Aadhar Act. 2016 and Prevention of Money Laundering Act and rules/regulations made thereunder for validating/authenticating my/our Aadhar details and updating the same in all my polices held with the company

_____ **Date**

_____ **Signature ofProposer**

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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.

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:
IMD Code:
IMD Sign*:

Proposer name:
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:
Signature:

Proposer Name:
Signature/thumb impression

10. For office use only

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

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11. Receipt of 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: