



URN - LH002V022021

Group Hospi-Cash Connect Policy Proposal Form

For Office Use Only

| | |
|--|--|
| Product Name: | Product Code: |
| Intermediary / Agent / Broker Name: | Intermediary / Agent / Broker Code: |
| IMD / Agent / Broker Contact No | Email ID |
| Sales Manager Name: | Sales Manager Code: |
| Product Name: | Product Code: |

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.

| | |
|--|---|
| <p>GUIDELINES TO FILL THE FORM</p> <p>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.</p> | <p style="text-align: center;">GOING GREEN JUST GOT EASIER!!! SAVE PAPER. SAVE TREES.</p> <p style="text-align: center;">I wish to avail physical policy document YES <input type="checkbox"/></p> |
|--|---|

Company/Proposer Details

Name of the Proposer / Organization / Group Administrator:

| |
|--|
| |
|--|

Address of Proposer / Organization / Group Administrator (Permanent Address / GST Red Address or Corporate Office):

| | |
|---------------------|---|
| Address: | |
| | |
| | City/Town: |
| District: | State: |
| Pin Code: | Country: |
| Telephone: | Mobile: |
| Nationality: | <input type="checkbox"/> Indian <input type="checkbox"/> Others (Please specify): |
| Occupation: | <input type="checkbox"/> Business <input type="checkbox"/> Others (Please Specify): |

Preset Address: Is your present address same as permanent address? Yes No

| | |
|------------------|-------------------|
| Address: | |
| | |
| | City/Town: |
| District: | State: |
| Pin Code: | Country: |

Business of Proposer / Organization / Group Administrator:

| | |
|--------------------------|--|
| <p>Type of Customer:</p> | <p>Government Co <input type="checkbox"/> Public Co <input type="checkbox"/> Pvt Co <input type="checkbox"/> Partnership Firm/LLP <input type="checkbox"/> HUF <input type="checkbox"/> Trust <input type="checkbox"/> Cooperative Society <input type="checkbox"/> Section 8 Co <input type="checkbox"/> Others (Please Specify) _____</p> <p>Whether Proposer /insured is a Non Profit Organization – Yes <input type="checkbox"/> No <input type="checkbox"/> If Yes, Please provide Darpan Registration No : _____</p> |
|--------------------------|--|

| | | | |
|---|--|-------------------|--|
| Date of Incorporation: | | Mobile No: | |
| Contact Person: | | Email ID: | |
| CKYC No: | | GSTN No: | |
| PAN No / Form 60 (if PAN not available): | | | |
| Annual Turnover: | | | |

I, _____, hereby grant explicit consent to Liberty General Insurance Company for the retrieval and downloading of my CKYC record from the Central KYC Records Registry. I understand that this information is essential for the purpose of ensuring accurate and updated records for insurance services. I acknowledge that Liberty General Insurance Company will handle my CKYC information in compliance with all applicable data protection laws and regulations. This consent is valid until revoked in writing by me. I have read and understood the terms and conditions regarding the usage of my CKYC information and voluntarily provide my consent.

Customer Name: _____ Date : _____

| Beneficial Owner | | | |
|--|---|---|---|
| Full Name | | | |
| Date of Birth | | | |
| Nationality | | | |
| Address | | | |
| % Share Holding | | | |
| PAN no | | | |
| Politically Exposed Person (PEP) Declaration | <input type="checkbox"/> PEP <input type="checkbox"/> NO <input type="checkbox"/> Family Member / Close Relative / Associates to PEP | <input type="checkbox"/> PEP <input type="checkbox"/> NO <input type="checkbox"/> Family Member / Close Relative / Associates to PEP | <input type="checkbox"/> PEP <input type="checkbox"/> NO <input type="checkbox"/> Family Member / Close Relative / Associates to PEP |

Proposal Details

Proposed Policy Period: From

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| d | d | m | m | y | y | y | y |
|---|---|---|---|---|---|---|---|

 To

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| d | d | m | m | y | y | y | y |
|---|---|---|---|---|---|---|---|

Nature of Group: Employer–Employee Non-Employer-Employee

Policy Type: Individual

Business Type: New Business Renewal Business Rollover Business Endorsement Others (Please Specify) _____

Sum Insured: _____

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.

Proposed Insured Person(s) Details format

| Insured Person Details | Insured 1 | Insured 2 | Insured 3 | |
|---|-----------|-----------|-----------|-----|
| Emp No | | | | |
| Name of Employee/Primary member | | | | |
| Mobile No | | | | |
| Email ID | | | | |
| Name of Dependent | | | | |
| Permanent Address | | | | |
| Present Address | | | | |
| Relationship | | | | |
| Date of Birth | | | | |
| Date of Joining | | | | |
| Designation | | | | |
| Gender | | | | |
| Nationality | | | | |
| Annual Income | | | | |
| If Non-Indian; Please specify nationality | | | | |
| Pre-existing disease/Injury (Y/N) If Yes, details of the same | | | | |
| ABHA No | | | | |
| Aadhaar No | | | | |
| Pan No | | | | |
| Politically Exposed person | Y/N | Y/N | Y/N | Y/N |
| Bank Account Number | | | | |
| IFSC Code | | | | |
| Bank Name | | | | |
| Bank Branch Name | | | | |
| Do any of the proposed insured persons have / had any disability? | Y/N | Y/N | Y/N | Y/N |
| Name of Disability | | | | |
| Percentage of disability | | | | |
| Type of Impairment | | | | |
| UDID | | | | |

| Nominee Details | 1st Nominee | 2nd Nominee | 3rd Nominee | 4th Nominee |
|--|-------------|-------------|-------------|-------------|
| Nominee Name and Relationship | | | | |
| Date of birth of nominee | | | | |
| Percentage of nomination | | | | |
| Mobile No of Nominee | | | | |
| Email ID of nominee | | | | |
| Present and Permanent address of Nominee | | | | |
| Bank Account Details: | | | | |

| | | | | |
|--|--|--|--|--|
| Beneficiary Name: | | | | |
| Bank Name: | | | | |
| Bank Account Number: | | | | |
| IFSC Code | | | | |
| MICR Number | | | | |
| Branch | | | | |
| Appointee Name if in case of Minor Nominee | | | | |
| Appointee Relationship if in case of Minor Nominee | | | | |

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 | | | | | | | | | | |

Previous Policy Terms and Conditions

Additional Information (If any)

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.
- 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.
- Liberty General Insurance (LGI/Liberty") will not be deemed to provide cover nor be liable to pay any claim or provide any benefit hereunder to the extent that the provision of such cover, payment of such claim or provision of such benefit would expose Liberty or its parent to any sanction, prohibition or restriction under United Nations resolutions or the trade or economic sanctions, laws or regulations of India, the European Union, United Kingdom, United States of America or other applicable jurisdiction.

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:

IMD Code:

IMD Sign:

*Stamp in case of Company

Proposer name:

Proposer sign:

DECLARATION WHEN THE PROPOSAL FORM IS FILLED BY A PERSON OTHER THAN THE PROPOSER / THE PROPOSER SIGNS IN A VERNACULAR LANGUAGE / PROPOSER IS ILLITERATE OR DISABLED

I hereby declare that I have read out and explained the content of this proposal form and all other connected documents incidental to availing the insurance policy from Liberty General Insurance. to the proposer and that he/she confirmed that he/ she has understood the same and that he/ she agrees to abide by all the terms & conditions of the same.

I hereby declare that I have fully explained to the proposer the answers to the questions that form the basis of the contract of insurance have also explained the contents in this form to the proposer in _____ language, that I have truly and correctly recorded the answers given by the proposer and that the proposer has affixed his/ her thumb impression on the proposal form in my presence, after fully understanding the contents thereof. Further, this declaration does not confirm issuance of policy or assumption of risk thereof.

I hereby state that the contents of the form and documents have been fully explained to me and that I have fully understood the significance of the proposed contract.

Name of Proposer:
Name of Witness:
Relationship with Proposer:
Address of Witness:

Signature of Proposer:
Signature of Witness:
Date:
Place:

Payment details

| Instrument type (Cash/Cheque/DD/EFT/Others) | Name of the premium payer | Cheque No / EFT No | Cheque Date | Premium 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:

| | | | | | | | | | | | | | | | | | | | | |
|----------------------------|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|
| Name of the Account Holder | | | | | | | | | | | | | | | | | | | | |
| Bank Name | | | | | | | | | | | | | | | | | | | | |
| Branch | | | | | | | | | | | | | | | | | | | | |
| City | | | | | | | | | | | | | | | | | | | | |
| Account No | | | | | | | | | | | | | | | | | | | | |
| IFSC Code | | | | | | | | | | | | | | | | | | | | |

Account Type: Savings Current

AML Details:

Are you or any of the proposed applicants a PEP* or Family member/ Close relatives/Associates of PEPs*? Yes No

If yes, please give details (Nature of relationship and position held by PEP): _____

*Politically Exposed Persons” (PEPs) are individuals who have been entrusted with prominent public functions by a foreign country, including the heads of States or Governments, senior politicians, senior government or judicial or military officers, senior executives of state-owned corporations and important political 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 have been/will be paid from Bonafide sources and no premiums have been/will be paid out of proceeds of crime related to any of the offence as listed in Prevention of Money Laundering Act, 2002 & its subsequent amendments thereof I/We understand that the Company has the right to call for documents to establish sources of funds.

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. Any person making default in complying with the provisions of this section shall be liable for a penalty which may extend to ten lakhs.

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: _____

Liberty General Insurance Limited