Liberty General Insurance Limited
10th Floor, Tower A, Peninsula Business Park,
Ganpatrao Kadam Marg, Lower Parel, Mumbai - 400 013
Phone: +91 22 6700 1313 Fax: +91 22 6700 1606
Email: care@libertyinsurance.in
IRDA registration number: 150 ● CIN: U66000MH2010PLC209656

HEALTH CONNECT SUPRA POLICY PROPOSAL FORM

URN: LH017V12021

Guidelines to fill the form

1. Please answer all the questions completely.
2. 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.

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.

Proposer Details

Last Name First Name Middle Name

Proposer (Mr / Mrs / Ms) :

Address :

City/Town : State :

District : Pin Code :

Telephone : Mobile :

E-mail :

Date of Birth : Gender :

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 :

Proposal Details

Business Type : ☐ New ☐ Renewal ☐ Rollover Policy Tenure : ☐ 1 Year ☐ 2 Years ☐ 3 Years Policy Type : ☐ Individual ☐ Family Floater

Proposed Policy Period : From d d m m y y y y To d d m m y y y y Plan Type : ☐ Top Up ☐ Super Top Up

Cover Proposed

	Insured Member I	Insured Member II	Insured Member III	Insured Member IV	Insured Member V
Name	Last Name First Name Middle Name	Last Name First Name Middle Name	Last Name First Name Middle Name	Last Name First Name Middle Name	Last Name First Name Middle Name
Relationship with Proposer					
Gender					
Date of Birth					
Height (cm)					
Weight (Kg)					
Occupation					
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.'

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Plan Details : Applicable for Individual Sum Insured Proposal/s

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 ☐ AYUSH Treatment ☐ World-wide coverage ☐ Wellness & Assistance Program ☐	Reload of Sum Insured ☐ AYUSH Treatment ☐ World-wide coverage ☐ Wellness & Assistance Program ☐	Reload of Sum Insured ☐ AYUSH Treatment ☐ World-wide coverage ☐ Wellness & Assistance Program ☐	Reload of Sum Insured ☐ AYUSH Treatment ☐ World-wide coverage ☐ Wellness & Assistance Program ☐	Reload of Sum Insured ☐ AYUSH Treatment ☐ World-wide coverage ☐ Wellness & Assistance Program ☐
World-wide coverage : Available for Super Top up Plan ONLY					

Plan Details : Applicable for Family Floater Proposal/s

Option	Option I ☐ Option II ☐ Option III ☐
Sum Insured (In Lakhs)	
Deductible (In Lakhs)	
Optional Cover(s)	Reload of Sum Insured ☐ AYUSH Treatment ☐ World-wide coverage ☐ Wellness & Assistance Program ☐

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

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, suffer from or have been treated for any heart related ailment/blood pressure/Diabetes/Cancer? Yes ☐ No ☐
2. Does any person, proposed to be insured, suffer from Paralysis/Asthma/Epilepsy? Yes ☐ No ☐
3. Does any person, proposed to be insured, suffer from any other disease/ailment/had any Injury? 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 ☐

   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 Hospitalizarion (If any)	Is it fully cured
1						
2						
3						
4						
5						

Additional Information (If any)

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?

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 :

Health Connect Supra Policy UIN : LIBHLIP21502V022021

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Liberty General Insurance

Payment Details

Instrument Type (Cash / Cheque / DD / Others)	Name of the Premium Payer	Bank Name	Cheque Date	Amount in INR

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:

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.
- Are you or any of your relative a Politically Exposed Person? Yes ☐ No ☐
  If yes, please provide details : _____

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.

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 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

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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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.

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.

For Office Use Only

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

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Receipt of Acknowledgement

Application Number : | | | | | | | | | | | 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 INR _____ 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.

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Signature of the Receiver & Office Seal : _____