Liberty General Insurance Ltd.
Unit 1501&1502, 15th Floor, Tower 2, One International Center,
Senapati Bapat Marg, Prabhadevi, Mumbai – 400013,
Phone: +91 226700 1313 Fax: +91 226700 1606
Toll Free : 1800 266 5844
IRDAI of India Reg. No.150, CIN: U66000MH2010PLC269656
Website Link: www.libertyinsurance.in

HEALTH PRIME CONNECT
Proposal Form

URN: LHPC20V12024

For Office Use Only

Product Code:	**Proposal Number**
Intermediary/Agent/Broker Name:	**Intermediary/ Agent/Broker Code:**
Sales Manager Name:	**Sales Manager Code:**
Branch Name	
Business Type : New ☐ Renewal ☐ Rollover ☐ Endorsement ☐ Other ☐	**(Please Specify)_____**

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. I wish to avail physical policy document **Yes ☐**

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

Proposer(Mr./Mrs./Ms.)	**First Name**	**Middle Name**	**Last Name**
Permanent Address:		**City/Town:**	
District:		**State:**	
Pin Code:		**Mobile:**	
Present Address:		**Nationality**	**Indian ☐ Others (Please Specify) :**
		Residential Status	**Resident Indian ☐ Non Resident Indian☐ Other :**
		City/Town:	
District:		**State:**	
Pin Code:		**Mobile:**	
Telephone:		**E Mail:**	
Date of Birth:		**Gender:**	**Male ☐ Female ☐ Others ☐**
Annual Income:	**Less than 5 Lacs ☐** **Between 5 - 10 Lacs ☐** **Between 10 - 20 Lacs ☐** **20 Lacs and above ☐**	**Marital Status:**	**Married ☐ Unmarried ☐**
		Educational Qualification	

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Occupation: **Salaried ☐** **Self Employed ☐** **Business☐** **Others ☐ Details:_____**
Nature of Business / Self Employed Details:_____

Liberty Employee No. (if applicable): _____

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

Type of Customer:

Individual ☐	☐ Government Co. ☐ Public Co. ☐ Pvt Co.
Partnership Firm/LLP ☐	☐ HUF ☐ Trust ☐ Cooperative Society ☐ Section 8 Co.
Others (Please Specify) :	

For Non-Individuals, Details of Beneficial Owner:
Mention the details of Individual persons who has/have the Beneficial Ownership in the captioned entity.

Full Name	Date of birth	Nationality	Address	% share holding	PAN	Politically Exposed Person (PED) declaration
						☐ PEP ☐ No ☐ Family member/Close Relatives/Associates to PEP
						☐ PEP ☐ No ☐ Family member/Close Relatives/Associates to PEP

Whether Proposer /insured is a Non Profit Organization: **Yes ☐** **No ☐**

If NPO, Please provide Darpan Registration No : _____

Pan Number	
Form 60/61 (If PAN not available)	☐ **Yes**
Aadhar/Driving License/Election Card/Passport/MNREGA Card Number	
GSTIN Number	
***CKYC Number**	

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.

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2. Plan Details

Business Type		☐ New	☐ Renewal	☐ Roll Over
Policy Type		☐ Individual	☐ Family Floater	
Policy Tenure		☐ 1 Yr	☐ 2 Yr	
Instalment Option If, Yes, Premium payment frequency		☐ Yes ☐ Monthly	☐ No ☐ Quarterly	☐ Half Yearly
Proposed Policy Period		From (date) DD/MM/YYYY	To (date) DD/MM/YYYY	
Sum Insured (In Lacs)				
Plan		☐ Essential	☐ Optimum	☐ Optimum Plus
Optional Cover	Cumulative Bonus Enhancer		☐ Yes	☐ No
	OPD cover		☐ 10000 ☐ 15000 ☐ 20000 ☐ 30000	☐ 10000 ☐ 15000 ☐ 20000 ☐ 30000
	Personal Accident Cover		☐ Yes	☐ No
	Critical Illness Sum Insured (As per the Plan Selected)		Available as per the Plan	☐ INR 5 Lakhs ☐ INR 10 Lakhs
	Personal Accident Cover (Capital Sum Insured)		☐ 100% of Basic Sum Insured ☐ 150% of Basic Sum Insured	☐ 100% of Basic Sum Insured ☐ 150% of Basic Sum Insured
	Adventurous Sports Cover		☐ Yes	☐ No
	Worldwide coverage		☐ Yes	☐ No

Details of Other Health Insurance Products till date

Product Name	Policy No. / Proposal No.	Period of Insurance	Sum Insured	Claims lodged during policy period (Yes/No)

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3. Proposed Insured(s) Details

	Proposed Insured I	Proposed Insured II	Proposed Insured III	Proposed Insured IV	Proposed Insured V
Name					
Relationship with Proposer					
Gender					
Date of Birth					
Age					
Height					
Weight					
Profession / Occupation	**Salaried¨ Self Employed¨ Others¨_____**	**Salaried¨ Self Employed¨ Others¨_____**	**Salaried¨ Self Employed¨ Others¨_____**	**Salaried¨ Self Employed¨ Others¨_____**	**Salaried¨ Self Employed¨ Others¨_____**
First Policy Inception Date of any other Insurer:	**dd-mm-yyyy)**	**dd-mm-yyyy)**	**dd-mm-yyyy)**	**dd-mm-yyyy)**	**dd-mm-yyyy)**
****ABHA No**					
Aadhaar No					
Pan No					
Politically Exposed person	Y/N	Y/N	Y/N	Y/N	Y/N
Nationality (Indian/Non Indian/Non-Resident Indian/Others)					
If Non-Indian; Please specify nationality					
If Non-Indian; Please specify Overseas Address					
If NRI; Please specify Resident Country name					
If NRI; Please specify Overseas Address					
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.					
Please affix a passport size photograph against corresponding Proposed Insured Person Name	Photograph Proposed Insured I	Photograph Proposed Insured II	Photograph Proposed Insured III	Photograph Proposed Insured IV	Photograph Proposed Insured V
Digital KYC Process to Differently Abled Persons					
1. Differently Abled Status					
2 Type of Impairment					
3 Percentage of Impairment					
4 UDID (Unique Disability ID) Number					
Name of illness/injury suffering from or suffered in the past					

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Date of first diagnosed/detected					
Treatment/medication received/ receiving					
Details of Hospitalisation (If any)					
Is it fully cured					

Nominee Details	1st Nominee	2nd Nominee	3rd Nominee	4th Nominee
Nominee Name and Relationship				
Date of birth of nominee	DD/MM/YY	DD/MM/YY	DD/MM/YY	DD/MM/YY
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 Relationshipif in case of Minor Nominee				

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

Sr.No.	Section A - Medical and Lifestyle Information	Insured 1	Insured 2	Insured 3	Insured 4	Insured 5
1.	**Hypertension (High Blood pressure) History:**	Y N	Y N	Y N	Y N	Y N
	a) Duration					
	b) Medications					
	c) Related Complications if any					
	d) Hospitalization if any					
2.	**Diabetes Mellitus (Sugar) History:**	Y N	Y N	Y N	Y N	Y N
	a) Type I or Type 2					
	b) Duration					
	c) Medications - Insulin/ Tablets					
	d) Related Complications if any					
	e) Hospitalization if any					
3.	**Hyperlipidemia (Cholesterol) History:**	Y N	Y N	Y N	Y N	Y N
	a) Duration					
	b) Medications					
4	Does any of the proposed insured person uses Health Fitness App for Health Monitoring	Y/N	Y/N	Y/N	Y/N	Y/N
5	Is the average sleep habit of the proposed insured between 6-10 hours?	Y/N	Y/N	Y/N	Y/N	Y/N
6	Nature of work details					
7	Does any person proposed to be insured smoke or consume Tobacco in any form or alcohol. If yes, please indicate the quantity consumed. If not, please indicate "No".					

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	a) **Smoking:** Cigarettes/Bidi/Cigar	Y N	Y N	Y N	Y N	Y N
	1. Number of Cigarettes/Bidi/Cigar per day					
	2. Number of years					
	b) **Tobacco in any form**	Y N	Y N	Y N	Y N	Y N
	1. Amount per day					
	2. Number of years					
	c) Alcohol / Beer	Y/N	Y/N	Y/N	Y/N	Y/N
	1. Number of Units per day					
	2. Number of Years					
	c) **Pan Masala/Gutka** / Other	Y N	Y N	Y N	Y N	Y N
	1. Amount per day					
	2. Number of Years					

Section B: Have any of the proposed insured ever suffered from/currently suffering from any of the following	**Proposed Insured I**	**Proposed Insured II**	**Proposed Insured III**	**Proposed Insured IV**	**Proposed Insured V**
1. **Heart and Circulatory Conditions/Disorders**: chest pain, angina, palpitations, congestive heart failure, coronary artery disease, heart attack, bypass surgery/angioplasty/ PTCA, valve disorder/replacement, pacemaker insertion, rheumatic fever, congenital heart condition, varicose veins, clots in veins or arteries, blood disorders, anti-coagulant therapy etc.	Y/N	Y/N	Y/N	Y/N	Y/N
2. **Respiratory Conditions/Disorders:** Shortness/difficulty of breath, Tuberculosis, Asthma, Bronchitis, Chronic Obstructive Pulmonary Disease COPD, chronic cough, coughing of blood, etc. or any Other Lung / Respiratory Disease	Y/N	Y/N	Y/N	Y/N	Y/N
3. **Urinary Conditions/Disorders**: Blood in urine, increase in urinary frequency, painful/difficult urination Kidney and/or Bladder infections, stones of urinary system, kidney failure, dialysis or Any Other Kidney/Urinary Tract Or Prostate Disease	Y/N	Y/N	Y/N	Y/N	Y/N
4. **Musculoskeletal Conditions/Disorders**: Joint/back pain Arthritis, Spondylosis, Spondylitis, Spinal disorders/Surgeries Osteoporosis, Osteomyelitis Joint Replacement Or Any Other Disorder of Muscle/ Bone/ Joint/ ligaments, tendons or discs, gout, herniated disc, fractures/ accidents/ implants, amputation/prosthesis, Muscle weakness, Polio etc.	Y/N	Y/N	Y/N	Y/N	Y/N
5. **Digestive Conditions/Disorders:** Jaundice, chronic diarrhea, intestinal bleeding/problems/polyps, diseases of the pancreas, liver or gall bladder, hepatitis A/B/C/other, jaundice, Ulcerative colitis, Chron's disease, Inflammatory/Irritable bowel disease, Cirrhosis, unexplained weight loss or gain, eating disorder or any Other Gastrointestinal Condition	Y/N	Y/N	Y/N	Y/N	Y/N
6. **Cancer/Tumor:** Benign Or Malignant tumor, Any Growth/Cyst / Ulcer, any Cancer diagnosed earlier and/or treatment taken for Cancer.	Y/N	Y/N	Y/N	Y/N	Y/N
7. **Female Reproductive Conditions/Disorders:** Pelvic pain, abnormal, menstrual bleeding abnormal PAP smear, endometriosis, Fibroid, Cyst/ Fibroadenoma, Bleeding Disorder, Pelvic infection Or Any Other Gynecological / Breast cysts/lumps/tumor any other Gynecological disorder, menopause (to be filled for female lives only)	Y/N	Y/N	Y/N	Y/N	Y/N
8. **Brain/Nervous System/ Mental/Psychiatric Conditions/Developmental Disorders/Congenital/Birth defect**: Loss of consciousness, fainting, dizziness, numbness/tingling, weakness, paralysis, head injury, stroke, migraine headaches or chronic severe headaches, sleep apnea, multiple	Y/N	Y/N	Y/N	Y/N	Y/N

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sclerosis, seizures/epilepsy or any Other Brain/ Nervous System Disease, Mental/Psychiatric disorder, ADHD, autism, disability or deformity whether physical or mental, etc.					
9. **Metabolic, Endocrine Conditions/Disorders and autoimmune/genetic disorder:** Adrenal/pituitary disorders, thyroid disorder, lupus, scleroderma, thyroid disorders, Thalassemia, anemia, Hemophilia, Obesity and related surgeries, leukemia or any other blood disorder	Y/N	Y/N	Y/N	Y/N	Y/N
10. **Eye, Ear, Nose and Throat Disorders / Dental:** Cataract, glaucoma, Optic neuritis, retinal detachment, conjunctivitis, squint, ptosis, Blindness, refractive error/ spectacle number in diopters; otitis media, Deviated Nasal Septum, Otosclerosis, Loss of speech, Hearing loss, nasal polyps, chronic sinusitis Any other disorder of Ear, Nose and Throat or any disorder of Dental	Y/N	Y/N	Y/N	Y/N	Y/N
11. **Sexually Transmitted Diseases:** HIV/AIDS, immunodeficiency or any venereal disease (VD)/ sexually transmitted disease (STD)	Y/N	Y/N	Y/N	Y/N	Y/N
12. Is any female member pregnant, tested positive with a home pregnancy test, (If yes share the date of Delivery or ectopic pregnancy, infertility treatment, planning for surrogacy or oocyte donation	Y/N	Y/N	Y/N	Y/N	Y/N
13. Does the person proposed to be insured suffer from any chronic or long-term medical condition, or have any other disability, abnormality or recurrent illness or injury or unable to perform normal activities?	Y/N	Y/N	Y/N	Y/N	Y/N
14. Has any member consulted with or received treatment from any doctor or other health care provider for any other condition or symptom(s)/undergone any hospitalization/illness/surgery/ currently taking medication(s) for any condition or medical procedures (including diagnostic testing) or any vector borne disease like Dengue, Malaria, Chikungunya, etc.	Y/N	Y/N	Y/N	Y/N	Y/N
14. Psychiatric/mental illness or sleep disorders	Y/N	Y/N	Y/N	Y/N	Y/N
Section C: Have any of the proposed insured persons	**Proposed Insured I**	**Proposed Insured II**	**Proposed Insured III**	**Proposed Insured IV**	**Proposed Insured V**
Been addicted to alcohol/narcotics/habit forming drugs or under any detoxication therapy	Y/N	Y/N	Y/N	Y/N	Y/N
Been under any regular medication (self/prescribed including hormones or OC Pills)	Y/N	Y/N	Y/N	Y/N	Y/N
Undertaken any lab tests like blood/urine/stool or any imaging tests like sonography/MRI/CT/X-Rays in the last 5 yrs	Y/N	Y/N	Y/N	Y/N	Y/N
Undertaken any surgery or advised any surgery in the last 10 yrs or is a surgery pending?	Y/N	Y/N	Y/N	Y/N	Y/N
Suffered from any other illness/disease/accident/injury	Y/N	Y/N	Y/N	Y/N	Y/N
Is any of the proposed insured pregnant? If yes please specify expected date of delivery	Y/N	Y/N	Y/N	Y/N	Y/N
Any complaint of diabetes, hypertension or any complication during current or earlier pregnancy?	Y/N	Y/N	Y/N	Y/N	Y/N

Section d: Do any of the proposed insured persons have / had below complaints	**Proposed Insured I**	**Proposed Insured II**	**Proposed Insured III**	**Proposed Insured IV**	**Proposed Insured V**
1. Do you have or ever experienced Blurring of vision	Y/N	Y/N	Y/N	Y/N	Y/N
2. Do you have or ever experienced uncomfortable breathing or fatigue on exertion or on walking	Y/N	Y/N	Y/N	Y/N	Y/N
3. Do you have or ever experienced increased frequency of Urination	Y/N	Y/N	Y/N	Y/N	Y/N
4. Do you have or ever experienced recurring pain in Lower Legs or Joints	Y/N	Y/N	Y/N	Y/N	Y/N
5. Do you have or ever experienced recurring headache	Y/N	Y/N	Y/N	Y/N	Y/N
6. Do you have or ever experienced recurring difficulty in swallowing	Y/N	Y/N	Y/N	Y/N	Y/N
7. Have anyone experienced any unexplained weight loss or weight gain in past one year.	Y/N	Y/N	Y/N	Y/N	Y/N

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Please provide details of

1. **Hereditary medical history, if any:**

....

2. **Family Medical History**

   Have any Insured Member's natural parents, brothers or sisters had cancer, heart problems, hypertension, stroke, kidney, lung disease, diabetes or any hereditary disease (e.g. Alzheimer's disease, Parkinson's disease, mental disorder)? YES / NO

If Yes, please provide details

....

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? _______________

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 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 favor of 'Liberty General Insurance Limited' only

For NEFT Payments, please fill the Bank details mentioned below:

Bank Details of the Proposed Insured:

Name of Account Holder	
Bank Name:	
Branch:	
City:	

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Account No:	
IFSC Code:	
Account Type	**Savings** ☐ **Current** ☐

Card Details : Master / Visa / Rupay
Card No :

Name of Card Holder :
Card Expiry Date :

In case of cancellation of policy, if premium were paid through credit card the refund amount would be credited to your Source bank account.

I wish ☐ : Any refund due on the premium payment / any payment/claims will be directly credited to my aforesaid Bank Account.

Bank Details of the Nominee:

Name of Account Holder	
Bank Name:	
Branch:	
City:	
Account No:	
IFSC Code:	
Account Type	**Savings** ☐ **Current** ☐

Bima ASBA:

☐ "I hereby accord my consent to authorize '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 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) _____

☐ 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.

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8. 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 policy documents and endorsements
2. Portability Form
3. Renewal notices with claim 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.

9. 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 have also understood the disclosures mentioned above.

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.

I understand if a physical policy pack is required, I may request the insurance company at the call center number or email address mentioned on the company website to issue the same at the registered address mentioned above.

I/we aware of premium loading, (if any declared above) for diseases as declared / mentioned by me or us 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/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 understand that the Company has the right to call for documents to establish sources of funds.

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 Liberty General Insurance 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 Liberty General Insurance and / or Liberty General Insurance authorized personnel / agency shall be stored by Liberty General Insurance, throughout the term of my relationship with Liberty General Insurance and used for the purpose relating to my proposal for insurance cover and/or servicing policies issued in my favour, whether by LGI or its authorized

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Liberty General Insurance Ltd.
Unit 1501&1502, 15th Floor, Tower 2, One International Center,
Senapati Bapat Marg, Prabhadevi, Mumbai – 400013,
Phone: +91 226700 1313 Fax: +91 226700 1606
Toll Free : 1800 266 5844
IRDAI of India Reg. No.150, CIN: U66000MH2010PLC269656
Website Link: www.libertyinsurance.in

partners. I also understand that the said storage is necessary for my consumption of the services and consent to not hold Liberty General Insurance 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 vendors.

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**

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 or 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 prospectuses 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 Lakh rupees

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

D 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:			
Signature of Proposer:			
Signature of Witness:			
Date:		Place:	
Relationship with Proposer:			
Address of Witness:			

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10. 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
Registered Office:

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