



District:		State:	
Pin Code:		Country:	

Business of Proposer / Organization / Group Administrator:

Type of Customer:	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) _____ Whether Proposer /insured is a Non Profit Organization – Yes <input type="checkbox"/> No <input type="checkbox"/> If Yes, Please provide Darpan Registration No : _____
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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
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 To

d	d	m	m	y	y	y	y
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Nature of Group: Employer–Employee Non-Employer-Employee

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

Proposed Covers

Detailed Coverage	Please tick (✓) the Proposed cover			Please mention the Limits Proposed				
	Insured-1	Insured-2	Insured-3	Insured-4	Insured-1	Insured-2	Insured-3	Insured-4
Daily Hospital Cash Benefit – Illness/Injury								

Daily Hospital Cash Benefit – Only Accidents									
Single event No of days Limit									
Multiple Event Maximum No of days Limit									
Double ICU Benefit – Sickness									
Double ICU Benefit – Only Accidents									
Day Care Procedure Cash									
Deductible									
Family Floater Cover									
Waiting Period Waiver									
Hospitalisation due to Maternity									
Pre and Post natal Hospitalisation									
Section II – Personal Accident Benefit									
Benefit Opted (AD/PTD/PPD/TTD)									
Child Education Support									
Accidental Medical Expenses									
Transportation of Mortal Remains									
Performance of Funeral Ceremony									
Modification of Residence/ Vehicle									
Ambulance Hiring Charges									
PTD Enhanced Option									
Accidental Hospitalization Expenses (Inpatient)									
Accidental Hospitalization Expenses (Outpatient)									
Coma of Specified Severity									
Burns Cover									
Broken Bones									
Vacation Cancellation Cover									
Return to Home Benefit									
Section III – Critical Illness Benefit									
Critical Illness Benefit (Plan Details)									
Option to reduce Survival Period									
Waiting Period Waiver									
Second Opinion Cover									
Section IV – Vector Borne Diseases Benefit									
In-patient Hospitalization Benefit									
Double Vector Borne Diseases Benefit									
Waiting Period Waiver									
Section V – EMI Protector Benefit									
In Patient Hospitalisation Benefit									
Personal Accident Benefit									
Critical Illness Benefit									
Vector Borne Diseases Benefit									
Waiting Period Waiver									
Option to reduce Survival Period for CI									
Section VI – Loan Protector Benefit									

Personal Accident Benefit								
Critical Illness Benefit								
Critical Illness Plan								
Waiting Period Waiver								
Option to reduce Survival Period for CI								
Section VII – Infectious Diseases Benefit								
Set A: Infectious diseases								
Set B: HIV Infection								
Set C: Covid Infection								
Waiting Period Wavier								
Sum Insured Type (Common / Separate)								
Coverage Type (Diagnosis / Hospitalisation)								
Section VIII – Income Protection Benefit								
Loss of Income due to Disability								
Loss of Income Due to Critical Illness								
Critical Illness – Plan								
Waiting Period Wavier								
Option to reduce Survival Period for CI								
Optional Cover								
Surgical Benefit Cover								
Maternity Benefit Cover								
Double Maternity Benefit Cover								
Joint hospitalization Cover								
Convalescence Benefit								

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				

Medical and Lifestyle related Information:

Part A

N a m e	Loa n A c c o u n t n o.	D O B	Ge n d e r	Sufferin g/suffer ed from any disease / illness / Injury	Suffering/su ffered/treat ed for any heart related ailment / blood pressure / Diabetes / Cancer	Sufferin g/suffer ed from Paralysis / Asthma / Epilepsy	Any present/past history of surgery/medic ation/disabilit y/medical condition	Consump tion of Alcohol / Smoke / Pan Masala / others	If answer to any questions is Yes, please elaborate					
									Na me of illne ss / injur y suffe ring fro m	Date of first diag nose d / dete cted	Trea tmen t / medi catio n recei ved / recei ving	Detail s of Hospit alizatio n (If any)	Is it full y cur ed	

										or suffe red in the past				
				Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>						

Part B

Have any of the proposed insured ever suffered from/currently suffering from any of the following	Self	Spouse	Child-1	Child-2
HIV/AIDS/any sexually transmitted disorder				
Psychiatric/mental illness or sleep disorders				

(Individual member details to be furnished by way of annexure provided)

Additional Information (If any)

Previous/Existing Insurance Details (if any)

Year	Previous Policy Terms and Conditions	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											

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 authorised 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 board approved underwriting policy of the Insurer and that the policy will come into force only after full payment of the premium Chargeable.
- I/We further declare that insured represented under this proposal forms group within the meaning of the group guidelines issued by IRDAI and the group is formed for the purpose other than obtaining the insurance policy.
- 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 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 the hospital who at any time has attended on the life to be insured/insured person or from any past or present employer concerning anything which affects the physical and mental health of the life to be insured/insured person and seeking information from any Insurer to whom an application for insurance on the life to be insured/insured person 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 of the life to be insured/insured person 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 policies 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 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 services 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

*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
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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