Liberty General Insurance Ltd.
10th Floor, Tower A, Peninsula Business Park,
Ganpatrao Kadam Marg, Lower Parel, Mumbai – 400 013,
Phone: +91 226700 1313 Fax: +91 226700 1606
IRDAI Reg. No.150, CIN: U66000MH2010PLC269656

URN - LH015V32021

Liberty Group Health Policy – Proposal Form

Company/Proposer Details

Name of Insured/ Proposer				
Address of Insured/ Proposer				
Business of Insured/ Proposer				
Contact Person at Insured			Contact No.	
			Email Id	
Employer-Employee relationship (Yes/No)			If No, specify relationship	
Intermediary Details				
Name of the Intermediary				
Contact Person at Insured			Contact No.	
			Email Id	
TPA Details (incase of Renewal Business)				
Name of TPA				
Contact Details				

Policy Details

Period of Insurance	Risk Start Date	*dd/mm/yyyy*	Risk End Date	*dd/mm/yyyy*
Policy Type	Fresh / Own Renewal / Other Renewal		For how many years policy has been active	
Expiring Policy Details				
Existing Insurer Name				
Premium paid at inception (Exclusive of Service Tax)				
Premium addition during the year (Exclusive of Service Tax)				

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Premium deletion during the year (Exclusive of Service Tax)			
Final Premium (Exclusive of Service Tax)			
Member Details			
Basis of Premium Charging to be specified whether per Family or per Member covered.			
	No of Members	No of Dependents	Total
No. of Members at inception			
Addition during the year			
Deletion during the year			
Final no. of Members at expiry			
Members to be covered on Renewal / New *(Age band wise and Sum Insured wise demography to be provided as per attached format for each location)*			
Claim Details as on	*dd/mm/yyyy*		
	Reimbursement	**Cashless**	
Claims Paid as on date (Rs)			
Claims outstanding as on date (Rs)			
If OPD cover given, then mention OPD claims separately		Claim paid under Corporate Buffer Facility as on _ *dd/mm/yyyy*	
Total claims paid during the last two policy years immediately preceding the expiring year.		Total claims paid during the last three months of the preceding two years of policy immediately preceding to the expiring year.	
Family Details			
Family Definition and Size			

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Whether Additional Children Covered		Family/ Floater Sum Insured	
Whether Additional Relationships Covered, like brother/sister etc.		Age Limit for Primary Members	

Coverages / Benefits Details

Whether Existing Benefits covered under the expiring year policy to be continued as it is – Yes or No	
If No – Then changes required in the Coverage and Limit of benefits to be specified.	

List of Coverages / Benefits	**Existing Policy**	**Renewal Policy**	**Revised terms of coverage, if any**
Basic Cover			
Restrictions in Coverages			
Cappings applicable, if any			
Co-payment, if any			

Individual Member Details

Sr. No	Emp No	Name of Employee/Primary member	Name of Dependent	Relationship	DOB	DOJ	Designation	Gender	SI

Nominee Name & Relationship	Pre-existing disease/Injury (Y/N) If Yes, details of the same	*Whether Pregnant(Y/N) If Yes, please give no. of months pregnancy	Ac No	IFSC	Bank Name	Branch

*Applicable to female members and if opted for Maternity benefits.

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

Is any of the member or their family member a politically exposed person? If yes please provide details: _____

Agreement, Declaration & Authorization

"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/us 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/We understand that the information provided by me/us will form the basis of the insurance policy, is subject to 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 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 or from any past or present employer concerning anything which affects the physical and mental health of the life to be insured and seeking information from any insurance company to which an application for insurance on the life to be insured 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/our proposal including the medical records for the sole purpose of proposal underwriting and/or claims settlement and with any Government and/or Regulatory Authority.

_____ _____

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Date

Signature of Proposer/Authorized signatory

AML Details:

Please provide Permanent Account Number (PAN) if premium amount exceeds Rs. 1 Lac

_____

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 punishable with fine which may extend to ten lakh rupees.

Part F: 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 _____

Signature of the receiver & office Seal:

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Part G: For Office Use Only

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

Annexure – 1

Sr. No	Emp No	/Primary member	Name of Dependent	Relationship	DOB	DOJ	Designation	Gender	SI

Nominee Name & Relationship	Pre-existing disease/Injury (Y/N) If Yes, details of the same	*Whether Pregnant(Y/N) If Yes, please give no. of months pregnancy	Ac No	IFSC	Bank Name	Branch

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