

Liberty Secure Future Connect Group Policy Proposal Form

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.

<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”.</p> <p>2. Please attach extra sheets wherever the space is insufficient to provide the additional underwriting information. Put a (✓) mark wherever applicable.</p> <p>3. Kindly contact the Company's Office or Intermediary for any doubts or clarifications on the Proposal Form.</p>	<p>GOING GREEN JUST GOT EASIER!!! SAVE PAPER. SAVE TREES.</p> <p>How would you want the policy pack to be received?</p> <p>Electronic/Soft Copy <input type="checkbox"/> Physical/Hard copy <input type="checkbox"/></p>
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1. Company/ Proposer/Financier/Bank Details

Name of Entity:
Address:
Industry Type:
Contact Person:
Position:
Designated Email Address: **Fax:**
Contact No/Mobile No:
Email Address: **GSTN No:**
PAN No / Form 60:
CKYC No:
Nationality:
If Non-Indian, please specify Country:

2. Proposal Details

Business Type: New Renewal Rollover

Policy Type: Individual

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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Total No. of Members:

Proposed Covers:

Critical illness	Option A <input type="checkbox"/> Option B <input type="checkbox"/> Option C <input type="checkbox"/> Option D <input type="checkbox"/> Option E <input type="checkbox"/>	Involuntary Loss of Job	
Personal Accident	Option A <input type="checkbox"/> Option B <input type="checkbox"/>	30 day survival period	
Child Education Benefit		Permanent Partial Disability under Personal Accident	

3. Proposed Insured(s) Details

Name	Contact No.	Email Address	Occupation	Loan Account no.	DOB	Gender	Applicant/Co-applicant	Sum Insured	Pre-existing Disease	Height	Weight	Loan Amount	Purpose of Loan	Annual Income	Loan Tenure	EMI Amount	PAN No.	ABHA Number
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Permanent Address	Present Address	ABHA No	Nationality If Non Indian please specify Country Name	Ac No	IFSC code	Bank Name	Branch	Do any of the proposed insured persons have / had any disability?	Name of Disability	Percentage of disability
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Nominee Name & Relationship	Mobile No	Email ID	Specify % of claim	Permanent Address	Present Address	Nominee in case of Minor Details of Authorized person	Ac No	IFSC Code	Bank Name	Branch
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Medical and Lifestyle related Information:

Name	Loan Account no.	DOB	Gender	Suffering /suffered from any disease / illness / Injury	Suffering/suffered/treated for any heart related ailment / blood pressure / Diabetes / Cancer	Suffering/suffered from Paralysis / Asthma / Epilepsy	Any present/past history of surgery/m.edication/disability/medical condition	Consumption of Alcohol / Smoke / Pan Masala / others	If answer to any questions is Yes, please elaborate					
									Name of illness / injury suffering from or suffered in the past	Date of first diagnosed / detected	Treatment / medication received / receiving	Details of Hospitalization (If any)	Is it fully cured	
				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"/>						

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

4. Previous/Existing Insurance Details (if any)

Name of Insured	Amount Claimed	Amount Paid	Benefit under which claim is made	Year in which claim is made

5. Previous Policy Terms and Conditions

6. Additional Information (If any)

- 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 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 assured / 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 confirm the receipt of acknowledgement issued by Liberty General Insurance Limited against the premium paid by me toward health insurance policy.
- “I/we confirm and declare that I/we are not designated as “banned person” by UN or OFAC or any other regulator or Country. I/We further agree that if at the time of claim I/We are so designated or if the claim arises in a banned country, the Company shall not be liable pay any claim.”
- 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 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/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.

Important Note:

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

Yes No

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 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

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

9. For Office use only

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

10. Receipt of Acknowledgement

Application

No:

Date:

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:

ANNEXURE 'A'

Name	Contact No.	Email Address	Occupation	Loan Account no.	DOB	Gender	Nationality	Applicant/Co-applicant	Sum Insured	Pre-existing Disease	Height	Weight	Loan Amount	Purpose of Loan	Annual Income	Loan Tenure	EMI Amount	PAN No.	ABHA Number
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									Name of illness / injury suffering from or suffered in the past	Date of first diagnosed / detected	Treatment / medication received / receiving	Details of Hospitalization (If any)	Is it fully cured
				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"/>					