



## LIBERTY SURRO ASSURE Proposal Form

URN: LH015V12023

### For Office Use Only

|                                                                                                                                                                                                                   |                                         |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------|
| <b>Product Code:</b>                                                                                                                                                                                              | <b>Proposal Number</b>                  |
| <b>Intermediary/Agent/Broker Name:</b>                                                                                                                                                                            | <b>Intermediary/ Agent/Broker Code:</b> |
| <b>Sales Manager Name:</b>                                                                                                                                                                                        | <b>Sales Manager Code:</b>              |
| <b>Branch Name</b>                                                                                                                                                                                                |                                         |
| <b>Business Type : New <input type="checkbox"/> Renewal <input type="checkbox"/> Rollover <input type="checkbox"/> Endorsement <input type="checkbox"/> Other <input type="checkbox"/> (Please Specify) _____</b> |                                         |

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                                                                                 |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <p><b>GUIDELINES TO FILL THE FORM</b></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><b>GOING GREEN JUST GOT EASIER!!! SAVE PAPER. SAVE TREES.</b></p> <p>I wish to avail physical policy document</p> <p><b>Yes <input type="checkbox"/></b></p> |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------|

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

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

UIN: LIBHLIP24117V012324

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Liberty General Insurance Ltd.  
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Toll Free : 1800 266 5844  
IRDAI of India Reg. No.150, CIN: U66000MH2010PLC269656  
Website Link: [www.libertyinsurance.in](http://www.libertyinsurance.in)



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 <input type="checkbox"/>           | <input type="checkbox"/> Government Co. <input type="checkbox"/> Public Co. <input type="checkbox"/> Pvt Co.                                    |
| Partnership Firm/LLP <input type="checkbox"/> | <input type="checkbox"/> HUF <input type="checkbox"/> Trust <input type="checkbox"/> Cooperative Society <input type="checkbox"/> 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                                                                                            |
|-----------|---------------|-------------|---------|-----------------|-----|-----------------------------------------------------------------------------------------------------------------------------------------|
|           |               |             |         |                 |     | <input type="checkbox"/> PEP<br><input type="checkbox"/> No<br><input type="checkbox"/> Family member/Close Relatives/Associates to PEP |
|           |               |             |         |                 |     | <input type="checkbox"/> PEP<br><input type="checkbox"/> No<br><input type="checkbox"/> 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)                                | <input type="checkbox"/> 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

| Plan*                                                       | Plan 1 - Oocyte Donor        | Plan 2 - Surrogate Mother    |
|-------------------------------------------------------------|------------------------------|------------------------------|
| Policy Period                                               | 12 months                    | 36 months                    |
| Sum Insured (INR)                                           | INR 2 Lakhs                  | INR 3 Lakhs                  |
| Policy Type                                                 | Individual Sum Insured Basis | Individual Sum Insured Basis |
| Who are covered (Relationship with respect to the Proposer) | Oocyte Donor                 | Surrogate Mother             |

\*The Policyholder/Insured Person can opt either Plan 1 or Plan 2 under the product.

|                        |                                                                                 |
|------------------------|---------------------------------------------------------------------------------|
| Business Type          | New                                                                             |
| Policy Type            | Individual                                                                      |
| Plan Type              | <input type="checkbox"/> Oocyte Donor <input type="checkbox"/> Surrogate Mother |
| Proposed Policy Period | From (date) To (date)<br>DD/MM/YYYY DD/MM/YYYY                                  |

## 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                    |                                       |                                       |                                       |                                       |                                       |

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**\*\*If ABHA ID is not available, we urge you to visit [abdm.gov.in](http://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 |  |  |  |  |  |
| 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 Relationship if 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.     | <b>Hypertension (High Blood pressure) History:</b> | Y N       | Y N       | Y N       | Y N       | Y N       |
|        | a) Duration                                        |           |           |           |           |           |
|        | b) Medications                                     |           |           |           |           |           |
|        | c) Related Complications if any                    |           |           |           |           |           |

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|                    |                                                                                                                                                                      |   |   |   |   |   |   |   |   |
|--------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------|---|---|---|---|---|---|---|---|
|                    | d) Hospitalization if any                                                                                                                                            |   |   |   |   |   |   |   |   |
| 2.                 | <b>Diabetes Mellitus (Sugar) History:</b>                                                                                                                            | 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.                 | <b>Hyperlipidemia (Cholesterol) History:</b>                                                                                                                         | 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 |
| 5                  | Is the average sleep habit of the proposed insured between 6-10 hours?                                                                                               | 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". |   |   |   |   |   |   |   |   |
|                    | a) <b>Smoking:</b> Cigarettes/Bidi/Cigar                                                                                                                             | Y | N | Y | N | Y | N | Y | N |
|                    | 1. Number of Cigarettes/Bidi/Cigar per day                                                                                                                           |   |   |   |   |   |   |   |   |
|                    | 2. Number of years                                                                                                                                                   |   |   |   |   |   |   |   |   |
|                    | b) <b>Tobacco in any form</b>                                                                                                                                        | Y | N | Y | N | Y | N | Y | N |
|                    | 1. Amount per day                                                                                                                                                    |   |   |   |   |   |   |   |   |
|                    | 2. Number of years                                                                                                                                                   |   |   |   |   |   |   |   |   |
|                    | c) <b>Alcohol / Beer</b>                                                                                                                                             | Y | N | Y | N | Y | N | Y | N |
|                    | 1. Number of Units per day                                                                                                                                           |   |   |   |   |   |   |   |   |
|                    | 2. Number of Years                                                                                                                                                   |   |   |   |   |   |   |   |   |
|                    | c) <b>Pan Masala/Gutka / Other</b>                                                                                                                                   | 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. <b>Heart and Circulatory Conditions/Disorders:</b> 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. <b>Respiratory Conditions/Disorders:</b> 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. <b>Urinary Conditions/Disorders:</b> 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. <b>Musculoskeletal Conditions/Disorders:</b> 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. <b>Digestive Conditions/Disorders:</b> 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. <b>Cancer/Tumor:</b> 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. <b>Female Reproductive Conditions/Disorders:</b> 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. <b>Brain/Nervous System/ Mental/Psychiatric Conditions/Developmental Disorders/Congenital/Birth defect:</b> Loss of consciousness, fainting, dizziness, numbness/tingling, weakness, paralysis, head injury, stroke, migraine headaches or chronic severe headaches, sleep apnea, multiple sclerosis, seizures/epilepsy or any Other Brain/ Nervous System Disease, Mental/Psychiatric disorder, ADHD, autism, disability or deformity whether physical or mental, etc. | Y/N                       | Y/N                        | Y/N                         | Y/N                        | Y/N                       |
| 9. <b>Metabolic, Endocrine Conditions/Disorders and autoimmune/genetic disorder:</b> 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. <b>Eye, Ear, Nose and Throat Disorders / Dental:</b> 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. <b>Sexually Transmitted Diseases:</b> 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                       |
| <b>Section C: Have any of the proposed insured persons</b>                                                                                                                                                                                                                                                                                                                                                                                                                 | <b>Proposed Insured I</b> | <b>Proposed Insured II</b> | <b>Proposed Insured III</b> | <b>Proposed Insured IV</b> | <b>Proposed Insured V</b> |
| 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                |

**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: \_\_\_\_\_



| Instrument type<br>(Cash/Cheque/DD/Others) | Name of the premium payor | Installment<br>facility (Yes/No) | Bank Name | Cheque Date | Amount in Rs |
|--------------------------------------------|---------------------------|----------------------------------|-----------|-------------|--------------|
|                                            |                           |                                  |           | DD/MM/YYYY  |              |

[illegible][illegible]

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Toll Free : 1800 266 5844  
IRDAI of India Reg. No.150, CIN: U66000MH2010PLC269656  
Website Link: [www.libertyinsurance.in](http://www.libertyinsurance.in)



| 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.

## 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 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 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.

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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](http://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 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 initio and the premium paid shall be forfeited to the Company.

IMD name:

IMD Code:

IMD Sign\*:

\*Stamp in case of Company

Proposer name:

Proposer sign:

**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/

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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:         |  |        |  |

## 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:

UIN: LIBHLIP24117V012324

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