UIN: MAGHLIP23189V012223

MAGMA General Insurance Limited

Saksham Health Insurance - Proposal Form

Proposal No. _____

GUIDELINES FOR COMPLETION OF THE FORM

This policy is specially designed for Persons with Disability, Mental Illness and Persons with HIV/AIDS.

a. Persons with Disability shall be covered if 40% or more disability is certified by the Medical Board appointed by the government for certifying Disability as per The Rights of Persons with Disabilities Act, 2016.

- Please answer all questions correctly and completely.
- Information for fields marked with asterisk (*) are mandatory.
- Only Indian Nationals can be covered under this policy.
- Only one policy can be purchased for this product across all insurers.
- Note: The Coverage proposed for insurance is not covered until the proposal is accepted and premium is paid and the same is realized by Name of the Insurance Company.

Intermediary details	
Branch Name	Branch Code
Intermediary Name	Intermediary Code
Sales channel Type	If POSP then please provide the below:- a) PAN Card Number of POSP b) AADHAR Card Number of POSP
Intermediary contact details	Proposal Received On

PROPOSER DETAILS

Proposer Name (Mr./Ms./Mrs./Other)			
	(First Name)	(Middle Name)	(Last Name)
Occupation	❑ Salaried ❑ Self-employed ❑ Professional ❑ Others (please specify).....		Date of Birth* D D M M Y Y Y Y
Occupation & Nature of Business / work:			
Communication Address			
	City:	State:	Pin Code:
Landmark			
Phone No. STD Code _____	Landline No. _____	Mobile No.* _____	Email ID _____
Gender	❑ Male	❑ Female	❑ Other
Aadhaar No.		PAN No. (form 60/61)	
ABHA No.			

Please share ID and address proof for KYC purpose. If Pan is provided, please share Passport / Voter's card / Driving License / Aadhaar number or any other officially valid document.

❑ I/We hereby give my/our consent to the Company to verify and obtain my/our identity/address proof as well as the identity /address proof of the insured through Central KYC Registry or UIDAI or through any other permitted modes for the purpose of undertaking applicable KYC.

COVERAGE DETAILS

Policy Type	Individual	Policy Period	❑ 1 Year
Period of Insurance	From: D D M M Y Y Y Y To: D D M M Y Y Y Y	Sum Insured	❑ 400000 ❑ 500000
Coverage opted	❑ Pre-existing HIV/AIDS ❑ Pre-existing Disability ❑ Pre-existing HIV/AIDS and Disability		
Waiver of Co-payment opted	❑ Yes ❑ No	Category of Cover	Indemnity

DETAILS OF PERSON TO BE INSURED

Sr. No.	Name of the Insured	Nationality	Date of Birth	Age	Gender	Height	Weight	Pre-existing Diseases	Occupation	Marital Status	Relation with Proposer	ABHA No
1												

NOMINEE DETAILS

	Name	Date of Birth	Age	Relationship with Insured
1				

If the Nominee is minor, Name and Address of Appointee and Relationship with Minor:

	Name of the appointee	Date of Birth	Age	Relationship with Insured
1				

Previous/Existing Health Details of Insured:

Do you suffer from HIV/AIDS? ❑ Yes ❑ No

If Yes, please enclose a recent certificate of your current CD4 count (within past 30 days)

Current CD 4 count _____

Has your CD4 Count gone below 500 in the past 4 years? ❑ Yes ❑ No

If yes when and How many times _____

Do you suffer from any other illness / disease related to/ arising of/ associated to HIV/AIDS? ❑ Yes ❑ No

❑ Yes ❑ No

If Yes, please give details:-.....

Do you suffer from any disability as per the listed conditions mentioned below: ❑ Yes ❑ No

If Yes, please enclose Disability certificate mentioning percentage of disability wherever applicable.

1. Blindness ❑
2. Muscular Dystrophy ❑
3. Low vision ❑
4. Chronic Neurological conditions ❑
5. Leprosy Cured persons ❑
6. Specific Learning Disabilities ❑
7. Hearing Impairment (deaf and hard of hearing) ❑
8. Multiple Sclerosis ❑
9. Locomotor Disability ❑
10. Speech and Language disability ❑
11. Dwarfism ❑
12. Thalassemia ❑
13. Intellectual Disability ❑
14. Haemophilia ❑
15. Mental Illness ❑
16. Sickle Cell disease ❑
17. Autism spectrum disorder ❑
18. Multiple Disabilities including deaf/ blindness ❑
19. Cerebral Palsy ❑
20. Acid Attack victim ❑
21. Parkinson's disease ❑

Do you suffer from any pre-existing illness other than Disability or HIV AIDS mentioned above? ❑ Yes ❑ No

If Yes, please specify details and the no of years you are suffering: _____

Do you have any other physical disability arising out of any illness / disease condition? _____

Any other previous medical details _____

MAGMA General Insurance Limited

Previous/Existing Health Insurance details

Policy No. / Application No.	Insurer Name	Sum Insured	Period of Insurance (from – to)	Claims lodged during the preceding years

Do you have the same policy from one or the other insurer? ❑ Yes ❑ No If yes please share the details below:

Policy No. / Application No.	Insurer Name	Sum Insured	Period of Insurance (from – to)	Claims lodged during the preceding years

ELECTRONIC INSURANCE DETAILS OF PROPOSER

I want _____related information in – Physical Format- ❑ Yes ❑ No e-Format (electronic) as & when applicable- ❑ Yes ❑ No
Choose your Insurance Repository (For those selecting e-Format)
(a) NSDL Data Management Ltd.
(b) CDSL Insurance Repository Ltd
© Karvy Insurance Repository Ltd.
(d) CAMS Repository Services Ltd
I have e Insurance Account & the No. is _____
My CKYC No. (Central Know Your Customer registry number) is (If available) _____

Representative Details (only if eIA is to be opened for any other person other than Proposer and primary Insured)

Name (Mr./Ms./Mrs./Other)			
	(First Name)	(Middle Name)	(Last Name)
Gender	❑ Male ❑ Male ❑ Other		DOB: D D M M Y Y Y Y
	PAN No.		
Address 1			
Address 2			
Address 3			
			Pin Code:
Telephone Number		Mobile Number	
Relationship		Other Relationship	
Email Id		UID	
Landmark		State	
City		Country	

PREMIUM PAYMENT DETAILS

Name of Premium payer:	
Premium Payment Frequency:	Monthly / Quarterly / Half Yearly
Premium Amount: ₹	Cheque ❑ DD ❑ Debit Card / Credit Card
Instrument Type:	Cash/ Cheque/ Debit Card/ Credit Card/ Others: Please Specify:
Date (DD/MM/YYYY):	Cheque no.
Bank Name:	Bank Account Number:
IFSC Code:	Branch Name:

Cheque will be issued in the name of the Proposer only.

In case of cancellation of policy, if premium was paid through credit card the refund amount would be credited to Credit Card account directly or refund will be paid through cheque. Please provide the following bank details and a copy of Cancelled Cheque if you opt for direct credit of refund/ claim into your bank account:(Cancelled Cheque should be of the same bank account in which the refund needs to be credited directly.

Name of Account holder	
Cheque No	
Bank Name	
Branch Name	
Cheque Date	
Cheque Amount for ₹	
Name as in Bank Account	
Bank Account No.	
IFSC Code	
MICR Code	

Note: The Proposer agrees and undertakes to intimate in writing to <<Magma General Insurance Limited>> about any change in bank account details.
If ECS is selected, please submit the standing instruction form available at our branches.

Place:
Date: D D M M Y Y Y Y

Signature of proposer:

MAGMA General Insurance Limited

AGENT'S DECLARATION

I,_____ (Full Name) in my capacity as an Insurance Advisor/ Specified Person of the Corporate Agent/Authorised employee of the Broker/Relationship Officer, do hereby declare that I have explained all the contents of this Proposal Form, including the nature of the questions contained in this Proposal Form to the Proposer including statement(s), information and response(s) submitted by him/her in this Proposal Form to questions contained herein or any details sought herein will form the basis of the Contract of Insurance between the Company and the Proposer, if this Proposal is accepted by the Company for issuance of the Policy. I have further explained that if any untrue statement(s)/ information/response(s) is/are contained in this Proposal Form/including addendum(s), affidavits, statements, submissions, furnished/to be furnished, the Company shall have the right to vary the benefits which may be payable and further more if there has been a non-disclosure of any material fact, the policy issued to his/her favour pursuant to this Proposal may be treated by the Company as null and void and all premiums paid under the Policy may be forfeited to the company.

Date: D D M M Y Y Y Y

Place:_____

Signature of Agent: _____

Licence No. _____

DECLARATION & WARRANTY ON BEHALF OF ALL PERSONS PROPOSED TO BE INSURED

- 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 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/We declare and further consent to the company. Seeking medical information from any hospital who at any time has attended on the life to be insured/proposer or from any past or present employer concerning anything which affects the physical and mental health of the life to be assured/proposer and seeking information from any insurance company to which an application or insurance on the life to be assured/proposer has been made for the purpose of underwriting the proposal and /or claim settlement.
- v. I/We authorize the company to share information pertaining to my proposal including the medical records for the sole purpose of proposal underwriting and/ or claims settlement and with any Governmental and/or Regulatory Authority.
- vi. I/We aware of premium loading, (if any declared above) for habit's & diseases as declared / mention by me/ us above.
- vii. I/ We hereby agree to keep record of KYC details of all the individual members covered under the group insurance, and ensure to provide the details of beneficiaries to the Company as and when required.

VERNACULAR DECLARATION

** Applicable where the Proposer is illiterate or is suffering from a disability due to which writing is restricted or where the Proposer has signed in vernacular language. (Note: The below must be witnessed by someone other than the Advisor/Employee of the Company).

I/We certify that the product applied for by me/us and the contents of the Proposal Form have been clearly explained to me/us and I/we have fully understood them. I/We further certify that the replies in the Proposal Form have been recorded as per the information provided by me/us. I, (Full name of the witness) _____ (Relation with the Proposer) _____ adult and inhabitant of (city) _____ and residing at _____ do hereby certify that I have read out and explained the contents of the Proposal Form and all other documents incidental to availing the insurance policy from Magma General Insurance Limited, to the Proposer/Primary Insured and he/she/they have understood the same. I/we declare that whatever I/we have stated herein above is true and correct to the best of knowledge and belief.

Date: D D M M Y Y Y Y

Place: _____

Signature of the Witness _____

Signature/Thumb impression of the Proposer/Primary Insured _____

Proposer Declaration

(Certification where for any reason, the proposal and other connected papers are not filled in by the Proposer). The contents of the proposal form and connected documents have been fully explained to me and I have fully understood the significance of the proposed contract. The Proposal Form is filled by _____ under my instruction and I found it to be correct.

Date: D D M M Y Y Y Y

Signature of the Proposer: _____

MAGMA
General Insurance Limited

6. **AML Guidelines**

1. I/we hereby confirm that all premiums paid / payable in future are from bonafide sources and not paid out of proceeds of crime and that such premiums are not disproportionate to my/our income. I / we understand that the Company has the right to call for documents to establish sources of funds and to cancel the insurance policy in case I / we are found guilty by any competent court of law under any of the statutes, directly or indirectly governing the prevention of money laundering law in India.

   Date: D D M M Y Y Y Y Signature of the Proposer: _____

   Are you or any of the proposal applicants PEPs* or a close relative/associate of PEPs*? ❑ Yes ❑ No

   If yes, please share the details of "Politically Exposed Persons" (PEPs):

   *(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

2. **Additional Information:**

   Nationality: Indian ❑ Non-Indian ❑ If, Non-Indian, please specify Country: ----------

3. **Type of Organisation:** (Applicable where an organisation is the proposer. In case of proposer being Individual, Sole Proprietor or HUF, please select option X)

   (i) Corporations (ii) Trust (iii) Government (iv) Partnership / LLP (v) Non-Government Organisations
   (vi) Co-operatives (vii) Society (viii) Private Limited Company (ix) Public Limited Company (x) others, please specify----------

4. **Source of Funds for premium payment:**

   Business: ---------- Salaried: ---------- Others (please specify) ----------

Prohibition of Rebates Under Section 41of Insurance Law (Amendment) Act, 2015

1. 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 continuing the policy accept any rebate except such rebate as may be allowed in accordance with the published prospectus or tables of the Insurer.
2. If any person fails to comply with sub-regulation (1) above, he shall be liable to payment of a fine which may extend to Ten Lakh Rupees.

Acknowledgment

Proposal No._____ Date: D D M M Y Y Y Y

We acknowledge with thanks the receipt of your proposaland amount by Cash/Cheque/NEFT/Demand Draft/ Others _____ of amount of Rs. _____ dated _____ drawn on _____

Neither the submission to Us of a completed proposal for Insurance nor any payment for any policy sought obliges Us to agree to issue a policy, which decision is and always shall be in Our sole and absolute discretion. If We accept a proposal for Insurance, it shall be subject to the policy terms and conditions and We shall have no liability whatsoever if premium is not received by Us in full and in time or is not realized. If We do not accept the proposal, We will inform you and refund the payment after deducting the charges for pre-policy health checkup, if any, received from you without interest.

Signature of the receiver and office seal: _____