Unique Reference No: MHDI/Health/Retail/DoubleSuraksh/001
Double Suraksha UIN : MAGHLIP25035V012425

MAGMA HDI
General Insurance Company Ltd.

Double Suraksha
Proposal Form

Proposal No. _____

1. FOR OFFICE USE ONLY

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

GUIDELINES FOR COMPLETION OF THE FORM (TO BE FILLED BY PROPOSER)

Please answer all the questions fully and correctly. This proposal will be the basis of any insurance policy that We may issue. You must disclose all facts relevant to all persons proposed to be insured that may affect Our decision to issue a policy or its price, terms, conditions and exclusions. The policy shall become void at Our sole discretion, in the event of any untrue or incorrect statement, misrepresentation, non-description or non-disclosure in any material particular in the proposal form/personal statement, declaration and connected documents or any material information having been withheld by the Proposer or anyone acting on his behalf.

If there is insufficient space for you to provide information whether as requested or otherwise, please attach a separate sheet. If you are in any doubt, please seek the help of Our company representative or your insurance advisor. If We accept a proposal for insurance, it shall be subject to the Policy terms and conditions, and We shall have no liability to make any payment under the Policy if premium is not received by Us in full and in time or is not realized or non-fulfillment of pre-policy medical check-up or proposal is not accepted by Us.

All fields/details marked with * are mandatory.

2. PROPOSER DETAILS

Please fill up this form in CAPITAL LETTERS for yourself and each proposed insured person.

Proposer Name* (Mr./Ms./Mrs./Other)				
	(First Name)	(Middle Name)		(Last Name)
Marital Status	❑ Single	❑ Married		
Gender	❑ Male	❑ Female		❑ None of these
Nationality*		Date of Birth* D D M M Y Y Y Y		
Occupation	❑ Salaried	❑ Self-employed	❑ Professional	❑ Others (please specify).....
Annual Income (in ₹)	❑ < 3,00,000	❑ 3,00,000 – 10,00,000	❑ 10,00,001 – 25,00,000	❑ >25,00,000
Address for Correspondence*				
Landmark				
City:		State:		Pin Code:

Phone No. STD Code_____ **Landline No.** _____ **Mobile No.*** _____ **Email ID** _____

Are you a Magma HDI General Insurance Company Limited Employee? ❑ Yes ❑ No

Do you have any other Policy with Magma HDI General Insurance Company Limited: If yes, Employee ID: .....

PAN No | | | | | | | | | | | Passport No | | | | | | | | | | | | Voter's Card No | | | | | | | | | |

Driving License No | | | | | | | | | | Aadhaar number No | | | | | | | | | | | CKYC 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.

3. PLAN DETAILS*

Policy Type	❑ Individual ❑ Family Floater	**Policy Period**	❑ 1 Year ❑ 2 Years ❑ 3 Years
If Family Floater*, number of persons to be covered: Adults: ____ Children: ____ *(* - Max 4 Adults and 3 children)*		Premium Payment Frequency	❑ Single Premium ❑ Quarterly Instalment ❑ Monthly Instalment ❑ Half Yearly Instalment
Per Day Sum Insured	1,000 / 2,000 / 3,000 / 5,000 / 7,000 / 10,000 Per Day		
Cover applicability	30 days/ 60 days / 90 days / 120 days / 180 days		

Optional Cover Name	Opted / Not Opted
Convalescence benefit	❑ Yes ❑ No
Day Care Treatment Cash	❑ Yes ❑ No
Childbirth Hospital Cash	❑ Yes ❑ No
Worldwide Hospital Cash	❑ Yes ❑ No
Companion Benefit	❑ Yes ❑ No
Pre-Post Hospitalization Expenses	❑ Yes ❑ No
Increase in Deductible Sickness Hospital Cash	❑ Yes ❑ No
Reduction in Deductible Sickness Hospital Cash	❑ Yes ❑ No
Increase in Max days for ICU Benefit	❑ Yes ❑ No
Health Maintenance Benefit	❑ Yes ❑ No
Reduction of Preexisting disease waiting period	❑ Yes ❑ No
Reduction of Named Ailments waiting period	❑ Yes ❑ No

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4. DETAILS OF INSURED PERSONS TO BE COVERED

Details		Insured Person 1	Insured Person 2	Insured Person 3	Insured Person 4	Insured Person 5	Insured Person 6	Insured Person 7
Title								
Name*	(First Name)							
	(Middle Name)							
	(Last Name)							
Gender (Male/Female/None of these)								
Height* (cm)								
Weight* (kg)								
Eye Refractive Error Index (Left and Right Eye)								
Date of Birth* (DD MM YYYY)								
Relationship with Proposer*								
Occupation (Salaried/Self-employed/Professional/Others)								
ABHA No.								
Compassionate Benefit Sum Insured (To be Selected from Rs. 10L / 20L and 25L)#								

All Insured would have the same Sum Insured if the optional benefit selected

5. NOMINATION

Policyholder is the nominee for all Insured members. Below details are for nominee to Policyholder.

Name of Nominee	First	Middle	Last
Relationship with Proposer		Date of Birth	D D M M Y Y Y Y
Contact Number of Nominee			

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

Appointee Name	Relationship with Nominee	Contact Number of Appointee

6. EXISTING/PREVIOUS INSURANCE DETAILS

Is the proposer or the persons proposed, already insured under or proposed for a health insurance policy with Magma HDI General Insurance Company Limited or any other insurance company? ❑ Yes ❑ No

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?: D D M M Y Y Y Y

Insured Person Name (First, Middle, Last)	Insurer Name	Policy No./ Application No.	Period of Insurance		Sum Insured (₹)	Claims details, if any
			From	To		
			DD/MM/YYYY	DD/MM/YYYY		

If you want to avail the portability benefit from your existing insurance policy, please also submit to Us (as an annexure to this proposal form) all the policy documents relating to the existing policy in addition to the information given above

7. MEDICAL AND LIFESTYLE INFORMATION*

SECTION A: Have any of the person proposed to be insured ever suffered from / are suffering from any of the following: Please tick 'YES" for insured person wherever applicable and provide details in Section B	Yes / No	Insured Person 1	Insured Person 2	Insured Person 3	Insured Person 4	Insured Person 5	Insured Person 6	Insured Person 7
1. Hypertension History								
a) Duration								
b) Medication								
c) Dosage								
2. Diabetes Mellitus History								
a) Type 1 or Type 2								
b) Duration								
c) Medication								
d) Dosage								

	Yes / No	Insured Person No.
3. Heart and Circulatory Conditions/Disorders: chest pain, angina, high cholesterol/lipids, palpitations, congestive heart failure, coronary artery disease, heart attack, bypass surgery/angioplasty, valve disorder/replacement, pacemaker insertion, rheumatic fever, congenital heart condition, varicose veins, thrombosis, blood disorders etc.?	Y N	1 2 3 4 5 6 7
4. Urinary Conditions/Disorders: Blood in urine, urinary frequency, painful/difficult urination Kidney and/or Bladder infections, stones of urinary system, renal failure, dialysis or Any Other Kidney/Urinary Tract Or Prostate Disease	Y N	1 2 3 4 5 6 7
5. Musculoskeletal Conditions/Disorders: Joint/back pain Arthritis, Spondylosis, Joint Replacement Or Any Other Disorder of Muscle/ Bone/ Joint/ligaments, tendons or discs, gout, herniated disc, amputation/prosthesis	Y N	1 2 3 4 5 6 7
6. Respiratory Conditions/Disorders: 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	1 2 3 4 5 6 7
7. Digestive Conditions/Disorders: Jaundice, chronic diarrhea, intestinal bleeding/problems/polyps, diseases of the pancreas, liver or gall bladder, hepatitis A/B/C/other, jaundice, Cirrhosis, unexplained weight loss or gain, eating disorder or any Other Gastro Intestinal condition	Y N	1 2 3 4 5 6 7
8. Cancer/Tumor - Benign Or Malignant tumor, Any Growth/Cyst, any Cancer	Y N	1 2 3 4 5 6 7
9. Brain/Nervous System/ Psychiatric Conditions/Disorders: 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	Y N	1 2 3 4 5 6 7

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	Yes / No	Insured Person No.
10. Female Reproductive Conditions/Disorders: Pelvic pain, abnormal, menstrual bleeding abnormal PAP smear, endometriosis, Fibroid, Cyst/ Fibroadenoma, Bleeding Disorder, Pelvic infection Or Any Other Gynecological / Breast cysts/lumps/tumor	Y N	1 2 3 4 5 6 7
11. Is any female person proposed to be insured pregnant, tested positive with a home pregnancy test, or in the process of adoption or becoming a surrogate?	Y N	1 2 3 4 5 6 7
12. Metabolic and Endocrine Conditions/Disorders: Adrenal/pituitary disorders, lupus, scleroderma, thyroid disorders, any autoimmune/genetic disorder	Y N	1 2 3 4 5 6 7
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	1 2 3 4 5 6 7
14. Does the person proposed to be insured use tobacco products/cigarettes or drinks alcohol?	Y N	1 2 3 4 5 6 7
15. Does any of the person proposed to be insured suffers from any infertility related condition?	Y N	1 2 3 4 5 6 7
16. Has any person proposed to be insured consulted with or received treatment from any doctor or other health care provider for any other condition or symptom(s)/any psychiatric condition/ undergone any hospitalization/illness/surgery/ currently taking medication(s) for any condition or medical procedures (including diagnostic testing)	Y N	1 2 3 4 5 6 7
17. Have you or any of the persons proposed to be insured been diagnosed with or undergone surgery for any of the following Critical Illnesses, prior to proposing for this cover - Cancer, Heart Attack, Coronory Artery, Bypass Graft, Heart Valve Replacement/ Repair, Coma, Kidney Failure, Stroke, any Transplant, Paralysis, Multiple Sclerosis, Motor Neurone Disease or HIV/AIDS	Y N	1 2 3 4 5 6 7
For Accidental Death/PTD Cover		
18. Has any of the applicants suffered or currently suffering from seizure disorder or any physical or mental defects/ impairment/ infirmity/deformity or any condition that may effect mobility/ sight/hearing/speech?		
19. Does the applicant's occupation require him/her to engage in hazardous activities or handling hazardous material or working at heights, as cabin crew, in sea/river faring vessels, with high voltage, or be a part of armed forces?		

SECTION B: Name and details of Illness / Medicine / Test / Surgery / Diopter grade (for questions answered as yes in SECTION A above)	Date of Last Consultation	Doctor's Name	Hospital Name & Phone No.	Ailment Details
Insured Person 1:				
Insured Person 2:				
Insured Person 3:				
Insured Person 4:				
Insured Person 5:				
Insured Person 6:				
Insured Person 7:				

Any other details: _____

Please add additional sheets if required.

Section C: Important Notes:

1. The information that you give to Us on this proposal form or in any supplementary information form or documentation supplied by you or on your behalf will influence Our decision to offer insurance and the terms upon which to offer it. Further, any policy We issue will be based on what you have communicated to Us. It is therefore important that your answers are complete and accurate in all respect.
2. The questions in this proposal are indicative rather than exhaustive. You must provide Us with all information relevant to the risk to be insured, even if it is not the subject of a question in this proposal. If you are in any doubt as to what information should be given, you should liaise with your insurance advisor/ company.
3. Acceptance of your proposal would be subject to receipt of complete medical reports (wherever applicable), medical underwriting and realization of full premium amount by the company and the insurance coverage will commence from the date of underwriting by the company.
4. The list of exclusions/ inclusions and other policy details are indicative, for complete list and comprehensive details kindly refer policy wordings.

Section D: Family Physician details:

Name:	Contact No.:

8. PAYMENT DETAILS

1. Payment Details: Please tick (✓) payment option Premium Amount (₹) _____ ❑ Cash ❑ Cheque/NEFT/DD Payment Option ❑ Digital Payment

   Cheque/NEFT/DD Number _____ Cheque/NEFT/DD Date D D M M Y Y Y Y Bank _____

2. For payment of claims/refund through direct bank transfer, please provide the following details: (please enclose a cancelled cheque along with the proposal form)

   Name of the Account Holder _____

   Name of the bank _____ Branch _____ City _____

   Account Type _____ IFSC Code _____ Account Number _____

Declaration:

"I/We hereby declare and undertake that the amount paid by me/us as premium for aforementioned policy is out of my/our lawful and declared source of income."

Electronic Clearing Service (Debit Clearing) Mandate Form

Proposal No. _____ Policy: _____

To,

Magma-HDI General Insurance Company Ltd., Development House, 24 Park Street, Kolkata – 700 016

Ref: Authorization of customer to remit funds/payments to <Bank Name> through Electronic Clearing Service

Customer Information:

a) Account Holder(s) Name (As appearing in the Bank Records			
b) Bank Name		c) Bank Branch Name	
d) Address		e) Branch City	
f) Account Type		g) Account No.	
h) Ledger No./Ledger Folio No.		i) 9 Digit MICR Code	

Unique Reference No: MHDI/Health/Retail/DoubleSuraksh/001
Double Suraksha UIN : MAGHLIP25035V012425

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Declaration:

I wish to avail the electronic clearing facility and hereby express my unconditional consent to debit premium for my health insurance policy applied vide proposal form no. _____ through participation in Electronic Clearing System (ECS). I, understand and agree that premium amount to be debited from my account may vary due to change in age bracket of the senior most member insured under the policy, change in applicable premium rates by the insurer, taxes and other statutory levies as may be applicable from time to time.

(Please refer to sales brochure for approximate premium details due to change in age applicable at the time of renewal)

I, hereby declare that the particulars given are correct and complete. I understand and accept that the transaction will be effected on the due date as opted by me in this form subject to the payment of premium on the policy (provided the day is a working day). If the transaction is delayed or not effective at all for reasons of incomplete or incorrect information, I/we would not hold the user institution responsible. I/We have read all the terms and conditions as are applicable for availing of this ECS Debit service from/through the user institution and agree to discharge the responsibility expected of me/us as a participant under the scheme.

I/We also hereby authorize representative of Magma HDI General Insurance Company Ltd. carrying this ECS Debit Mandate Form to get it verified and executed by my/our Bank.

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

_____
Signature of applicant

9. ELECTRONIC INSURANCE DETAILS OF PROPOSER

Do you wish to have this Policy credited to an eIA? (Please select any one)

❑ No, I do not have an eIA and do not wish to open one ❑ Yes, Credit this Policy to my e-Insurance account

If yes, Please share existing e-Insurance Account No_____

Please select Insurance Repository Name (you have opened your account with)

❑ M/s NSDL Database Management Limited ❑ M/s Karvy Insurance Repository Limited

❑ M/s Central Insurance Repository Limited ❑ M/s CAMS Repository Services Limited (Please select any one) Or

❑ I do not have existing e-Insurance account and I am interested in creating a new e-Insurance account (Please submit electronic insurance account opening form (eIA form) along with relevant documents)

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)

First Name _____ Middle Name _____ Last Name _____

Gender ❑ Male ❑ Female ❑ None of these Date of Birth* D D M M Y Y Y Y PAN No.

Address Line 1

Address Line 2

Address Line 3

Pincode Telephone Number Mobile Number

Relationship _____ Other Relationship _____ Email Id _____

UID _____ Land Mark _____ State _____

City _____ Country _____

10. DECLARATIONS

1. **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 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 any time 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.

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

Place: _____ Name of Proposer: _____

2. **Authorization for electronic policy fulfillment and service communications (Please read carefully and put a check mark against each before signing)**

I hereby consent that the policy documents may be sent to me by email at _____ (Please provide us your e-mail id) or via sms at my mobile no. provided above" can be added to all proposal forms.

I hereby consent to and authorize Magma HDI General Insurance Company Limited (" Company") to make welcome calls, service calls or any other communication (electronic or otherwise) with respect to the proposed or existing policy of Company from time to time and subject to the provisions of applicable law.

I wish to get all policy related communications on My WhatsApp number

Whatsapp Number: _____

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

Place: _____ Name of Proposer: _____

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3. **Vernacular Declaration**
I hereby declare that I have fully explained the contents of the proposal form and all other documents incidental to availing the health insurance from Magma HDI General Insurance Company Limited to the proposer in the language understood by him/her. The same have been fully understood by him/her and the replies have been recorded as per the information provided by the proposer. Replies have been read out to, fully understood and confirmed by the proposer.

Declarants Name_____

Relationship with proposer _____

Signature of declarant: _____ Signature of applicant in vernacular: _____

Date: D D M M Y Y Y Y

4. **Intermediary Declaration**
I, _____ (Full Name) in my capacity as an Insurance Advisor/Specified Person of the Corporate Agent/Authorized 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 responses(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, or 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 premium paid under the Policy may be forfeited to the Company.

License No./ID (Advisor/Corporate Agent/Broker/Relationship Officer)
Date: D D M M Y Y Y Y Signature of the Insurance Advisor: _____

I [name of proposer] confirm that I have understood all the features/benefits available under this Policy.

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

5. **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: _____

6. **AML Guidelines**

1. I/we hereby confirm that all premiums paid / payable in future will be 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 applicant are PEPs* or a close relative of PEPs*? ❑ Yes ❑ No
If yes, please share the details "Politically Exposed Persons" (PEPs):
*(PEPs) are individuals who are or have been entrusted with prominent public functions in a foreign country, e.g., Heads of States/Governments, senior politicians, senior government/judicial/military officers, senior executives of state-owned corporations, important political party officials, etc.

2. **Additional Information:**
Nationality: Indian ❑ Non-Indian ❑ If, Non-Indian, please specify Country: ----------

3. **Type of Organisation:**
(i) Corporations (ii) Trust (iii) Government (iv) Partnership (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:**
Business: ---------- Salaried: ---------- Others (please specify) ----------

11. GENERAL INFORMATION

1. Caution

You are obliged to make a full and frank disclosure of all facts material to the assumption of risk in relation to you and every person proposed to be insured that would influence Our decision to issue the policy or the terms on which it is issued, and you must not misrepresent any information to Us. The obligation continues until the policy is issued and does not end with the submission of this proposal form. If, therefore, there is any change in the information given herein or new information comes to light before the policy is issued, then you must inform Us of the same in writing without delay. If there is insufficient space to provide additional information, whether as requested or otherwise, then please attach an extra sheet duly signed. If the disclosure obligations are breached then such breach may render any policy issued void.

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 proposal and 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, if any, received from you without interest.

Signature of the receiver and office seal _____