

ICICI LOMBARD COMPLETE HEALTH INSURANCE PROPOSAL FORM

For Official Use Only

Product Code: 4128

Intermediary ID : Branch Name : Proposal No. : Intermediary Name : Deal No. :

GUIDELINES FOR COMPLETION OF THE FORM (To be filled by proposer)

Please answer all the questions fully and correctly. Where any question does not apply, please mention clearly that the same is not applicable.

Insurance is a contract of Utmost Good Faith requiring the Insured not only to disclose all material facts but also not to suppress any material facts in response to the questions in the proposal form. Please disclose all material facts while filing in the proposal form.

The Policy shall become void at the option of Insurer, 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 any one acting on his behalf. Kindly contact the Company's Offices or Agents for any doubts or clarifications on the proposal form.

Terms and Conditions

- Initial waiting period of 30 days for all illnesses (except Hospitalization due to injury or Accident)
- Specific waiting period of first two years for specific illnesses and treatments (mentioned in the policy wording)
- Pre-existing conditions/ diseases declared and accepted by Us will be covered immediately after 2 years of continuous coverage under the policy
- Sum Insured can be changed at the time of renewal only. Company reserves right to approve/reject the change in Sum Insured. Fresh waiting period as per the terms of the policy will be applicable to the enhanced limit from the effective date of such enhancement.
- Factors determining the renewal premium are (i) age slab of the senior most insured member at the time of renewal (ii) any change in the renewing policy.
- The liability of the Company does not commence until this Proposal has been accepted by the Company and premium realised

Signature of proposer/customer: Date: / / Place:

PROPOSER / CUSTOMER INFORMATION

Please fill all the particulars in CAPITAL letters only

Proposer's Name (please leave a space after each part of name)

Mr. / Ms. / Dr. : Date of Birth : Gender : Male ☐ Female ☐ Third gender ☐Marital Status : Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐Occupation : ☐ Salaried ☐ Self Employed ☐ Professional ☐ Retired ☐ Housewife ☐ Student ☐ Others Details Nationality: ☐ Indian ☐ Others (please specify) Residential Status: ☐ Indian Resident ☐ Non Resident IndianEducational Qualifications: ☐ Lesser than matriculation ☐ Matriculation ☐ Graduate ☐ Post-graduate ☐ Professional CourseAnnual Income : ☐ Less than 5 Lacs ☐ Between 5 - 10 Lacs ☐ Between 10 - 20 Lacs ☐ 20 Lacs and aboveGST Number: (If Applicable) PAN Card No.: Passport No. Aadhaar No. Correspondence Address : Landmark : City : State : Pin code : Landline Number (with STD Code) : Mobile Number* : E-mail address : Permanent Residence Address : Landmark : City : State : Pin code :

*Kindly provide the details to enable us to serve you better

NOMINEE DETAILS

Name of Nominee : Date of Birth : Relationship :

DETAILS OF APPOINTEE (Details to be filled only if nominee is a minor)

Appointee Name : Relationship with Proposer :

FAMILY PHYSICIAN DETAILS

Name of Physician : Landline Number (with STD Code) : Mobile Number :

DETAILS OF PERSONS TO BE INSURED

Insured No.	Full Name (First, Middle, Last)	Gender (M/F/T)	Date of Birth (DD/MM/YY)	Relationship with Proposer	Height (feet/inch)	Weight (kgs)	PAN No.
1.							
2.							
3.							
4.							
5.							

Are all insured Indian nationals and Indian residents? Yes ☐ No ☐ If Not, please provide details:

DETAILS OF OTHER HEALTH INSURANCE POLICIES IN EXISTENCE

Is any proposer or the person proposed, already insured under a plan with ICICI Lombard GIC Ltd? Yes ☐ No ☐

If yes please indicate below the Policy number(s) (Please mention proposal number in case of pending proposal.)

Insured Name	Policy No. / Proposal No.	Period of Insurance	Sum Insured	Claims lodged during policy period (Yes/No)

DETAILS OF THE INSURANCE PRODUCT/ PLANS

Please fill the form as per your health care needs.

ICICI Lombard Complete Health Insurance

Tenure	☐ 1 Year ☐ 2 Years ☐ 3 Years	Plan Type	☐ Individual ☐ Floater	Plan Options	☐ Individual 2A ☐ 2A+1C	☐ 1A + 1C ☐ 2A + 2C	☐ 1A + 2C ☐ 2A + 3C
Plan Details							
Sum Insured							
Add-ons Cover							

Medical Underwriting Required for person aged 46 years and above and/ or for Sum Insured option above 10 lacs.

Cost of Pre Policy Medical Check-up for policy issuance: 100% of the pre policy medical test cost will be paid by the Company. In case the health proposal is declined, medical cost will be deducted from the premium and the balance would be refunded.

PAYMENT DETAILS

Payment Option: Cheque ☐ DD ☐ Cheque/ DD Number: Dated: / /

[illegible]

BANK ACCOUNT DETAILS

For direct payment of claims/ refunds in the account, please fill the following:

Bank

Branch MICR [illegible]Account Number:

Account Type: ☐ Savings ☐ Current ☐ Cash Credit ☐ Overdraft

*Please enclose cancelled cheque along with the Proposal Form for direct payment in the account. In case the cheque doesn't bear a/c holder name or branch IFSC code or both, kindly fill the NEFT mandate form

AUTO - RENEWAL OPTION

Do You wish to avail an auto-renewal facility (ECS payment) by way of which we will automatically renew your Policy for the period for which it has been issued for. (Please tick Yes, if opted for) Yes No

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

Signature of the proposer/customer: _____ Place: _____ Date: / /

MEDICAL AND LIFESTYLE INFORMATION

Important: You must answer the following questions truthfully. Not doing so affects your coverage in case of a Claim.

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 wherever applicable and provide details in Section B

Sr.No.	Medical and Lifestyle Information	Insured 1	Insured 2	Insured 3	Insured 4	Insured 5
1.	Hypertension (High Blood pressure) History :	<u>Y</u> <u>N</u>	<u>Y</u> <u>N</u>	<u>Y</u> <u>N</u>	<u>Y</u> <u>N</u>	<u>Y</u> <u>N</u>
	a) Duration					
	b) Medications					
	c) Related Complications if any					
	d) Hospitalisation if any					
2.	Diabetes Mellitus (Sugar) History :	<u>Y</u> <u>N</u>	<u>Y</u> <u>N</u>	<u>Y</u> <u>N</u>	<u>Y</u> <u>N</u>	<u>Y</u> <u>N</u>
	a) Type I or Type 2					
	b) Duration					
	c) Medications - Insulin/ Tablets					
	d) Related Complications if any					
	e) Hospitalisation if any					

Sr.No.	Medical and Lifestyle Information	Insured 1	Insured 2	Insured 3	Insured 4	Insured 5
3.	Hyperlipidemia (Cholesterol) History: a) Duration b) Medications	<u>Y</u> <u>N</u>	<u>Y</u> <u>N</u>	<u>Y</u> <u>N</u>	<u>Y</u> <u>N</u>	<u>Y</u> <u>N</u>
4	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) Smoking: Cigarettes/Bidi/Cigar 1. Number of Cigarettes/Bidi/Cigar per day 2. Number of years b) Tobacco in any form 1. Amount per day 2. Number of years c) Alcohol 1. Number of Units per week 2. Number of years	<u>Y</u> <u>N</u>	<u>Y</u> <u>N</u>	<u>Y</u> <u>N</u>	<u>Y</u> <u>N</u>	<u>Y</u> <u>N</u>
						Yes / No
5	Heart and Circulatory Conditions/Disorders: chest pain, angina, palpitations, congestive heart failure, coronary artery disease, heart attack, bypass surgery/angioplasty, valve disorder/replacement, pacemaker insertion, rheumatic fever, congenital heart condition, varicose veins, clots in veins or arteries, blood disorders, anti-coagulant therapy etc.					<u>1</u> <u>2</u> <u>3</u> <u>4</u> <u>5</u>
6	Urinary Conditions/Disorders: 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					<u>1</u> <u>2</u> <u>3</u> <u>4</u> <u>5</u>
7	Musculoskeletal Conditions/Disorders: 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					<u>1</u> <u>2</u> <u>3</u> <u>4</u> <u>5</u>
8	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					<u>1</u> <u>2</u> <u>3</u> <u>4</u> <u>5</u>
9	Digestive Conditions/Disorders: 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 Gastro Intestinal condition					<u>1</u> <u>2</u> <u>3</u> <u>4</u> <u>5</u>
10	Cancer/Tumor: Benign Or Malignant tumor, Any Growth/Cyst, any Cancer diagnosed earlier and/or treatment taken for cancer					<u>1</u> <u>2</u> <u>3</u> <u>4</u> <u>5</u>
11	Brain/Nervous System/ Mental/Psychiatric Conditions/Developmental Disorders/Congenital/Birth defect: 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.					<u>1</u> <u>2</u> <u>3</u> <u>4</u> <u>5</u>
12	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					<u>1</u> <u>2</u> <u>3</u> <u>4</u> <u>5</u>
13	Eye, Ear, Nose and Throat Disorders: Cataract, glaucoma, Opticneuritis, retinal detachment, conjunctivitis, squint, ptosis, Blindness, refractive error/ spectacle number in dioptres; otitis media, Deviated Nasal Septum, Otosclerosis, Loss of speech, Hearing loss, nasal polyps, chronic sinusitis Any other disorder of Ear, Nose and Throat					<u>1</u> <u>2</u> <u>3</u> <u>4</u> <u>5</u>
14	Sexually Transmitted Diseases: HIV/AIDS, immunodeficiency or any venereal disease (VD)/ sexually transmitted disease(STD)					<u>1</u> <u>2</u> <u>3</u> <u>4</u> <u>5</u>
15	Metabolic, Endocrine Conditions/Disorders and autoimmune/genetic disorder: Adrenal/pituitary disorders, thyroid disorder, lupus, scleroderma, thyroid disorders, Thalassemia, anemia, Hemophilia, Obesity and related surgeries, etc.					<u>1</u> <u>2</u> <u>3</u> <u>4</u> <u>5</u>
16	Is any female member pregnant, tested positive with a home pregnancy test, or ectopic pregnancy, infertility treatment					<u>1</u> <u>2</u> <u>3</u> <u>4</u> <u>5</u>
17	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?					<u>1</u> <u>2</u> <u>3</u> <u>4</u> <u>5</u>
18	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)					<u>1</u> <u>2</u> <u>3</u> <u>4</u> <u>5</u>
19	Does the individual have a family history of any disease (like Heart disease/ brain disease/ cancer/ organ failure/ autoimmune/ genetic disorder					<u>1</u> <u>2</u> <u>3</u> <u>4</u> <u>5</u>

*The above list of questions is subject to modification as per the requirement.

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.
Insured 1 :			
Insured 2 :			
Insured 3 :			
Insured 4 :			
Insured 5 :			

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 answer are complete and accurate in all respect.
2. The question 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.
5. The Policy shall become voidable at the option of the Company, in the event of any untrue or incorrect statement, misrepresentation, non- description or non-disclosure of material particulars in the Proposal Form/personal statement, declaration and connected documents, or any material fact* information has been withheld by beneficiary or anyone acting on beneficiary's behalf to obtain insurance.