Advanced Top Up Health Insurance Plan



PROPOSAL FORM

Proposal Form No.

	FOR OFFICE USE ONLY
Branch Name:	Branch Code:
Intermediary: Agency	y 🗌 Direct 🗎 Corporate Agency 🗎 Other Intermediary
Intermediary Name:	Intermediary Code:
Proposal Received On:	
Processed By:	Date D D M M Y Y Y Y Approved By: Date D D M M Y Y Y Y
Customer ID:	
	GUIDELINES FOR COMPLETION OF THE FORM (TO BE FILLED BY PROPOSER)
all persons proposed to b sole discretion, in the eve form/personal statement behalf. If there is insufficient space help of our company repr	estions fully and correctly. This proposal will be the basis of any insurance policy that We may issue. You must disclose all facts relevant 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 ent of any untrue or incorrect statement, misrepresentation, non-description or non-disclosure in any material particular in the proposal to, declaration and connected documents or any material information having been withheld by the Proposer or any one acting on his ce for you to provide information whether as requested or otherwise, please attach a separate sheet. If you are in any doubt, please seek the resentative or your insurance advisor. If We accept a proposal for insurance, it shall be subject to the Policy terms and conditions and We 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
•	PROPOSER DETAILS
Please fill up this form	in CAPITAL LETTERS for yourself and each proposed insured person
Mr. Mrs. Miss	
Name of the Proposer	First Name Last Name Last Name
Address for Correspondence	City State
Landmark	
Telephone	
Date of Birth DDD	
Education Qualification	☐ Lesser than matriculation ☐ Matriculation ☐ Graduate ☐ Post Graduate ☐ Professional Course
Occupation	☐ Salaried ☐ Self employed ☐ Student ☐ House wife ☐ Others
If salaried, specify design	nation
If self employed, specify	
Annual Gross Income (₹)	
E-mail*	
Ayushman Bharat Health	n Account (ABHA)
Please specify if you fall	under any of the listed categories. (please tick and give details where ever required)
1. Non Resident Ind	
2. Member of any T	
3. Politically Expose	ed Person (PEP): Senior Politician Senior Government Judicial Military Officer Senior Executive of State Owned Corporation Important Political Party Official
	☐ Head of State or of Government.

			Idito	w four cusic	MILIC (IC.	0, 2	2111	ILO			
Please provide you	ır Central Know You	our Custome	r registratio	on number below.							
CKYC Number											
If CKYC Number is not available, please confirm below on the documents being shared by you (proposer) to comply with KYC guidelines. (Please tick)											
1. ☐ PAN Card Copy (compulsory) 2. ☐ Form 60 (only if PAN is not available)											
3. Address Proof Driving License Voter's Identity Card Passport Copy NREGA Card											
·)							
4. Identity Proc	of (only for those s	submitting	Form 60)	☐ Driving Licen	se 🔲 V	oter's l	lden	tity C	ard	L	Passport Copy NREGA Card
*	officially valid doc		. ,	1 same document too.							
				COVERAGE	SELECTI	ON					
1. Plan details											
Policy Type:	Individual 🗌	☐ Family Flo	pater								
Tolley Type.	individuai	_ railing ric	Jatel								
*	number of persons	s to be cover	red	Adults	Chi	ldren					
(* - Max 2 Adults a	and 4 children)										
2. Proposed policy	y term										
Policy Tenure:	☐ 1 Year ☐ 2 Y	Years 🔲 :	3 Years								
3. Deductible and	Sum Insured (Ple	ease Select)									
Deductible	Sum Insured	,									
		15 lakhs	☐ 20 laki	ns	☐ 70 la	khs		95 lal	ths		
10 lakhs		40 lakhs	☐ 65 lak)	4110		
15 lakhs		35 lakhs	☐ 60 laki								
20 lakhs		55 lakhs	□ 80 lak								
		50 lakhs	☐ 75 laki								
_	·	•		or) to service your				_			
	alth Services (TPA)	,		edi Assist Insurance							ealth Insurance TPA Pvt. Ltd.
Note : The above is in co	mpliance with F.No. IRD	DAI / Reg/15/166	5/2019.Insuran	ce Regulatory and Develo	pment Author	rity of Inc	dia (T	hird Pa	rty A	dmin	istrators – Health Services) (Amendment) Regulations, 2019
			DET	AILS OF PERSO	NS TO BE	E COV	ÆRI	ED			
				Gende							
Sl. No	Insured Name (First,	t, Middle, Last	t)	Male / Female /			Da	te of b	irth	l	Relationship with proposer
1.						Г	D	ММ	lΥ	Υ	
2.						Г	D	ММ	lΥ	Υ	
3.						Г	D	ММ	lΥ	Υ	
4.						Г	D	ММ	lΥ	Y	
5.						Г	D	ММ	ΙY	Υ	
6.						Ε	D	M M	lΥ	Υ	
				OPTIONA	L COVE	₹ .					
1 Poduction in D	ro Evicting Disease	o waiting no	ried from	36 months to 24 n	nonthe	YES		1 NO			
Nomination	re-Existing Disease	c waiting pe	.riou iroin	30 months to 24 m	ionuis	IEc	, Г] NO			
	death of the propose	eer any navm	ent due un	der the policy shall b	secome na	zable te	o the	nom	ine	e nro	pposed in the form. The receipt of the proceeds
											nsured shall be the proposer himself/herself.
	to be filled by the pro										
Nomin	ee Name (First, Midd	dle, Last)	F	telationship with the	proposer				Add	ress	and contact details of Nominee
						Addr	ess				

Phone Number

	Electronic Insurance Account number												
	Would you like to open an Electronic Insurance Account with any Insurance Repository?												
	If yes, please furnish the below details.*												
	Insura	nce Repository Name											
	*Accoun	t will be opened with your Name / DOB / Add	fress as mentioned in this proposal for	rm.									
	If you already have an Electronic Insurance Account, please share the below details												
	Accou	nt Number											
	Accou	nt Name											
Insurance Repository Name													
	4. Medical questions Please answer the below mentioned questions accurately to the best of your knowledge in respect of each person proposed to be insured. If the answer to any of these questions is Yes, please provide the complete details in the table for additional medical information (Important – You must answer these questions												
	truthfully.) Please ensure that you are fully informed about the standard waiting periods and permanent exclusions that apply to this product. Questions (please answer Yes/No)												
	Sl.	ions (piease answer res/140)											
	No	Details		Insured 1	Insured 2	Insured 3	Insured 4	Insured 5	Insured 6				
	1	Have you or other family member or are suffering from any Pre-Exist as listed in Question 2) which has which you have been treated or ta	ting Disease (PED) (except ve been diagnosed and for	YES NO									

Questions (please answer Yes/No)

application? If 'Yes' please specify

Sl. No	Details	Insured 1	Insured 2	Insured 3	Insured 4	Insured 5	Insured 6
2	Have you or other family members proposed, ever suffered from or are currently suffering from or under regular treatment for any major Illness like Sarcoidosis, Cancer, Heart Ailment Congenital heart disease and valvular heart disease, Heart Surgery like Angioplasty, Coronary Artery Bypass Surgery, Cerebrovascular disease (Stroke), Inflammatory Bowel Diseases, Chronic Liver diseases, Pancreatic diseases, Chronic Kidney disease, Hepatitis B, Alzheimer's Disease, Parkinson's Disease, Demyelinating disease, HIV & AIDS, Loss of Hearing, Papulosquamous disorder of the skin, Avascular necrosis (osteonecrosis), any major Organ Failure, Genetic disorder like Down Syndrome, Huntington's Disease etc? If 'Yes' please specify	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	YES NO	YES NO	YES NO

Note: Basis the response of above questions your case may be referred to Medical Underwriting.

or medication, Within the last 4 years, prior to this

5. Additional Medical Information

If you have answered yes to any of the questions in section 4, please give full details here. If you need more space please use extra sheets. If you are unsure whether any details are relevant, please include them.

Details	Insured 1	Insured 2	Insured 3	Insured 4	Insured 5	Insured 6
Name of illness/injury suffering from or suffered in the past						
Date of first diagnosis (Month & Year)						
Treatment/medication received/receiving						
Treatment outcome (fully cured/partially cured/ ongoing, etc)						

 $\textbf{Note:} Company\ may\ apply\ an\ exclusion\ based\ upon\ the\ declarations\ made\ in\ the\ proposal\ form\ and\ the\ health\ status\ of\ the\ members\ proposed\ to\ be\ insured.$

 $Any \, exclusion, if applicable, shall \, be \, suitably \, intimated \, to \, the \, proposer \, based \, on \, the \, assessment \, of \, the \, proposal \, form \, and \, medical \, tests.$

GENERAL INFORMATION

1 Existing Insurance Details

If any of Insured persons proposed to be insured is already insured under or proposed for a health insurance policy with
Royal Sundaram General Insurance Co. Limited or any other insurance company.

	Insured Name	Insurer Name	Sum Insured (Rs.)
Insured 1			
Insured 2			
Insured 3			
Insured 4			
Insured 5			
Insured 6			
2. Caution You are obliged to would influence of the policy is issue information come additional information and policy. 3. Authorization of the provided in the policy i	o make a full and frank disclosure of all facts may decision to issue policy or the terms on which ed and does not end with the submission of es to light before the policy is issued, then you action, whether as requested or otherwise, ther issued void. For electronic policy fulfillment and service coent that the policy documents may be sent to make us your e-mail id) sent to and authorize Royal Sundaram General	nation given above aterial to the assumption of risk in relation to you it is issued and you must not misrepresent any it this proposal form. If therefore, there is any or must inform us of the same in writing without please attach an extra sheet duly signed. If the mmunications (Please read carefully and put a content of the elements of the eleme	make welcome calls, service calls or any other
Date: DDM	MIYIYIYI	Signature of the Proposer :	
Date .			
Place :		Name of Proposer :	
4. Declaration			
	, on my behalf and on behalf of all persons proposed est of my knowledge and that I am authorized to propo		or particulars given by me are true and complete in all
_	at the information provided by me will form the basis orce only after full payment of the premium chargeable	1 // /	d underwriting policy of the insurer and that the policy
	that I will notify in writing any change occurring in tication of the risk acceptance by the company.	he occupation or general health of the life to be insure	ed/proposer after the proposal has been submitted but
any past or pres	ent employer concerning anything which affects the J	· · · · · · · · · · · · · · · · · · ·	attended on the person to be insured/proposer or from proposer and seeking information from any insurer to proposal and/or claim settlement.
	company to share information pertaining to my propertilement and with any Governmental and/or Regulato	71 1	oser for the sole purpose of underwriting the proposal

5. Vernacular Declaration

Place : __

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 Royal Sundaram General Insurance Co. 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 and the replies have been read out to fully understood and confirmed by the proposer.

Name of Proposer :

Declarants Name																																
Relationship with	1	l	I		1	ı	ı	1	ı	l	1	I		l	l	1	1		1	ı	1	1	ı	- 1	ı		-	- 1				

gnature of declarant :	Signature of applicant in vernacular :

Premium Amount (₹)									
Premium Amount (₹) (In words									
Cheque/NEFT/DD Payment Option:									
Cheque/NEFT/DD Amount (₹) Cheque/NEFT/DD Number									
Cheque/NEFT/DD Date D D M M Y Y Bank Bank									
For Auto-debit facility, you are required to submit Auto-debit authorization form separately.									
For Cheque/DD (Payable in favour of Royal Sundaram General Insurance Co. Ltd)									
7. Bank Account Details: 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 Bank Branch City									
IFSC Code Account Number									
Account Holder's Name Sign Here X Place: Signature of Applicant									
Intermediary Declaration I,									

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



Royal Sundaram General Insurance Co. Limited

Vishranthi Melaram Towers, No. 2 / 319, Rajiv Gandhi Salai (OMR), Karapakkam, Chennai - 600097. Registered Office: 21, Patullos Road, Chennai - 600 002.

Royal Sundaram IRDAI Registration No.102 $\,\mid\,$ CIN: U67200TN2000PLC045611



Advanced Top Up Health Insurance Plan



Date DDMMYYYY

Proposal Form No.

ACKNOWLEDGEMENT

e acknowledge with thanks the receipt of your proposal and amount by Cash/Cheque/NEFT/DD/Others of
mount of ₹dated
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either 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 ad always shall be in out 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 a liability whatsoever if premium is not received by us in full and in time or is not realized. I we do not accept the proposal, we will inform you and refund the syment, if any, received from you without interest.
gnature of the receiver and office seal
Royal Sundaram General Insurance
Royal Sundaram General Insurance Co. Limited Vishranthi Melaram Towers, No. 2 / 319, Rajiv Gandhi Salai (OMR), Karapakkam, Chennai - 600097.
Registered Office: 21, Patullos Road, Chennai - 600 002.
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↑ 1860 425 0000



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