

**SARAL SURAKSHA BIMA,
ROYAL SUNDARAM GENERAL INSURANCE CO. LIMITED.
PROPOSAL FORM**



FOR OFFICE USE ONLY

Customer ID: _____

Saral Suraksha Bima, Royal Sundaram General Insurance Co. Limited. | PR24213/MAR25

COVERAGE SELECTION

1. Plan details

Policy Type: ☐ Individual ☐ Family Cover*

*Proposer has to be mandatorily covered under the Family cover.

In case of Family cover, following shall be the sum insured limits for Family Members:

Self has to be earning and mandatorily have to be covered

☐ Self/Proposer - 100%

☐ Spouse - 50% of the sum insured of proposer

☐ Parents/Parents-in-Law - 25% of the sum insured of proposer for each

☐ Child/Children - 20% of the sum insured of proposer for each

If a higher sum insured is sought for any of the family members then they will have to opt for a separate policy, issuance of which shall be subject to the acceptance and income criteria guidelines.

2. Proposed Policy Term - 1 year

3. Sum Insured for Proposer - please specify the Sum Insured

Rs. 2.5 lakhs to Rs. 1 crore (in multiples of Rs. 50,000) _____

Rs. 1.5 crores to Rs. 5 crores (in multiples of Rs. 50 lakhs) _____

DETAILS OF PERSONS TO BE COVERED

Please repeat and share below for each proposed person for cover.

Sl No.	Name (Proposed Person)	Date of Birth	Gender	ABHA No.	Relationship to Proposer*	Occupation**	#Any existing Personal Accident policy with Royal Sundaram	##Optional covers
1			<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> 3 rd Gender					<input type="checkbox"/> TTD <input type="checkbox"/> HosExp <input type="checkbox"/> EduGra
2			<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> 3 rd Gender					<input type="checkbox"/> TTD <input type="checkbox"/> HosExp <input type="checkbox"/> EduGra
3			<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> 3 rd Gender					<input type="checkbox"/> TTD <input type="checkbox"/> HosExp <input type="checkbox"/> EduGra
4			<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> 3 rd Gender					<input type="checkbox"/> TTD <input type="checkbox"/> HosExp <input type="checkbox"/> EduGra
5			<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> 3 rd Gender					<input type="checkbox"/> TTD <input type="checkbox"/> HosExp <input type="checkbox"/> EduGra
6			<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> 3 rd Gender					<input type="checkbox"/> TTD <input type="checkbox"/> HosExp <input type="checkbox"/> EduGra

*Please choose the relationship with proposer from this list - Spouse as long as he or she continues to be married to you, Son, Daughter-in-law, Daughter, Father, Mother, Father-in-law as long as your spouse continues to be married to you, Mother-in-law as long as your spouse continues to be married to you, Grandfather, Grandmother, Grandson, Granddaughter, Son-in-law, Brother, Sister, Sister-in-law, Brother-in-law, Nephew and Niece.

** Please choose the occupation from this list - Salaried, Self Employed, Housewife, Student, Others.

##Optional Covers - Temporary total disablement/Hospitalisation Expenses due to Accident/ Education grant

#If yes please mention policy no _____

Please select Risk Class for each Insured Person (please tick the option relevant to you)

Risk Class	Please tick the option applicable to you.
RISK CLASS I - skilled white collar class with no exposure to occupational hazard Few indicative examples - Accountants, Doctors, Lawyers, Architects, Consulting Engineers, Teachers, Bankers, Persons engaged in administrative functions, house wife or any person not going out for work etc.	Insured Person 1 _____ Insured Person 2 _____ Insured Person 3 _____ Insured Person 4 _____ Insured Person 5 _____ Insured Person 6 _____ And so on
RISK CLASS II - skilled white collar class with minimal exposure to occupational hazard Few indicative examples - Builders, Contractors and Engineers engaged in superintending functions only etc.	Insured Person 1 _____ Insured Person 2 _____ Insured Person 3 _____ Insured Person 4 _____ Insured Person 5 _____ Insured Person 6 _____ And so on
RISK CLASS III - skilled/semi-skilled class with moderate exposure to occupational hazard Few indicative examples - Delivery boys, Diploma engineers working on shop floor etc.	Insured Person 1 _____ Insured Person 2 _____ Insured Person 3 _____ Insured Person 4 _____ Insured Person 5 _____ Insured Person 6 _____ And so on
RISK CLASS IV - unskilled class having high exposure to occupational hazard. Few indicative examples - Loaders, Mining workers etc.	Insured Person 1 _____ Insured Person 2 _____ Insured Person 3 _____ Insured Person 4 _____ Insured Person 5 _____ Insured Person 6 _____ And so on

POLICY DOCUMENTS DELIVERY PREFERENCE (Please select your preferred mode of receiving the policy documents):

- ☐ Electronic Copy only (via registered email/ mobile number)
- ☐ Both Electronic & Physical Copies*
- *Note: If you select both electronic and physical copies, the physical copy will be dispatched to your registered mailing address.

NOMINATION

In the event of the death of the proposer any payment due under the policy shall become payable to the nominee proposed in the form. The receipt of the proceeds by such nominee would be sufficient discharge to the company. Nominee for all other persons proposed to be insured shall be the proposer himself/herself. Nomination can be changed at any time during the term of the policy. Following section to be filled by the Proposer/Representative:

Nominee Name** (First, Last)	Relationship with the proposer	Address and contact details of Nominee	% of Sum Insured	Bank Account details of the Nominee
		Present Address Permanent Address Phone Number Email ID		1. Account No. _____ 2. IFSC Code _____ 3. Bank Name _____ 4. Branch Name _____ 5. Branch Code _____

Nominee Name** (First, Last)	Relationship with the proposer	Address and contact details of Nominee	% of Sum Insured	Bank Account details of the Nominee
		Present Address Permanent Address Phone Number Email ID		1. Account No. 2. IFSC Code 3. Bank Name 4. Branch Name 5. Branch Code
		Present Address Permanent Address Phone Number Email ID		1. Account No. 2. IFSC Code 3. Bank Name 4. Branch Name 5. Branch Code
		Present Address Permanent Address Phone Number Email ID		1. Account No. 2. IFSC Code 3. Bank Name 4. Branch Name 5. Branch Code

**Nominee for Primary insured/ Proposer may to be among the following mentioned relations

☐ Father ☐ Mother ☐ Son ☐ Daughter ☐ Spouse

In case the nominee is a minor then please provide the name and address of the Appointee -

Name of the Appointee	Name and address of the Appointee	Relationship with the Nominee	Age	Contact Number

ADDITIONAL MEDICAL INFORMATION

If you have answered yes to any of the Health 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)						

Note: Company may apply an exclusion/risk loading on the premium payable (based upon the declarations made in the proposal form and the health status of the members proposed to be insured). These loadings would be applied from the Policy Period State Date including all subsequent renewals with the company.

Any exclusion/loadings, if applicable, shall be suitably intimated to the proposer based on the assessment of the proposal form and medical tests. Proposer shall be required to pay the additional premium within stipulated time of such intimation. Company shall not be at any risk during this period. In the event of the decline of proposal due to non-receipt of this additional premium within the stipulated time or due to any reason, Company shall cancel your proposal and refund the premium amount after deducting charges as per policy terms and conditions.

OTHER ONGOING HEALTH INSURANCE / PERSONAL ACCIDENT / CRITICAL ILLNESS POLICY INFORMATION (including those obtained from Royal Sundaram General Insurance Co. Limited)

Sl. No	Name of Insured	Name and Address of insurance company	Policy No.	Period of Insurance first inception date	Period of Insurance		Sum Insured (₹)	Claim details, claim amount received or receivable (in ₹)	Are any persons to be insured opting for portability or migration from an existing cover?
					From	To			
1.					DDMMYYYY	DDMMYYYY			<input type="checkbox"/> YES <input type="checkbox"/> NO
2.					DDMMYYYY	DDMMYYYY			<input type="checkbox"/> YES <input type="checkbox"/> NO

*Note: In case of Portability/ Migration, kindly fill Portability/ Migration Request form along with this form

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 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 may render any policy issued void.

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 _____
WhatsApp at _____
- ☐ I hereby consent to and authorize Royal Sundaram General Insurance Co. 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.

Date :

D	D	M	M	Y	Y	Y	Y
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Signature of the Proposer / Representative : _____

Place : _____

Name of Proposer : _____

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.
- I declare that the premium amount, corresponding to this proposal, is paid out of the legally declared and assessed sources of my income and not out of proceeds of crime related to any Offence under the Prevention of Money Laundering Act, 2002 and rules framed thereunder. I understand that Royal Sundaram reserves the right to call for documents and information to establish the source of funds, as also the right to reject the said proposal or to terminate the insurance contract unilaterally and/or forfeit the premium amount, if I am found to be named in any recognized sanction list/happen to have violated any provisions of law.
- I confirm that the premium has been paid by _____, who has an insurable interest in my policy and refund, if any, shall be processed in my bank account.
- I am (please tick all that are applicable): ☐ HNI ☐ NRI ☐ Politically Exposed Person ☐ Jeweller ☐ NGO ☐ Film Actor ☐ Producer ☐ Others.
- ABHA Declaration (Applicable only if you have shared the ABHA number with Us) - I, hereby declare that I am voluntarily sharing Ayushman Bharat Health Account number (ABHA No) for the proposed Insured Persons, with Royal Sundaram, for the sole purpose of accessing my records of medical history, which will be used to verify/share relevant information provided herein on confidential basis within its Group and /or third party agencies in connection with the Claims, for the purpose of facilitating insurance/ reinsurance services and ancillary services.
- I consent to the fact that Royal Sundaram may download my/proposer's CKYC record from the Central KYC Records Registry, in relation to the verification of my/proposer's KYC records as part of this proposal. I understand that acceptable officially valid documents shall be relied upon for the said verification of KYC records. I, also, consent to receive information from the Central KYC Registry through SMS/email on the above-mentioned mobile phone number/email address. It is, also, confirmed that the KYC records available in the CKYC Registry are current and valid, as on the date of this proposal, and can be used by Royal Sundaram hereafter. In case of any modification, the applicable information will be provided to Royal Sundaram for updating the CKYC Registry Records.
- I further confirm that I have read and understood the contents of this proposal form, including the terms, conditions, and disclosures provided by the insurer. I have been given an opportunity to seek clarifications, and I am fully aware of the implications of the coverage, premium payments, and policy terms.

Date :

D	D	M	M	Y	Y	Y	Y
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Signature of the Proposer/Representative : _____

Place : _____

Name of Proposer : _____

I, _____, hereby authorize _____ (my relationship to proposer: _____) to complete this proposal form on my behalf, as I require assistance due to my disability. I confirm that all information provided is accurate and given with my full consent.

Date: |D|D|M|M|Y|Y|Y|Y|

Note: The insurer may request identification proof of the authorized representative if required.

The terms, conditions, and benefits of the insurance product, its scope of coverage, exclusions, premium details, my rights, obligation and duties was explained to me in my preferred language(dialect) by the persons. Additionally, I was also provided with an opportunity to ask question and seek clarification in my preferred language(dialect) before authenticating this proposal

Signature of the Proposer/Representative: _____

Name of Proposer : _____

Witness Name:	Intermediary / Agent Name:
Witness Signature:	Intermediary / Agent Signature:
POSP Name:	POSP Code:
POSP PAN No.:	Date and Place:

(For blocking the premium amount under BIMA ASBA facility)

(Savings/Current): _____

Date : |D|D|M|M|Y|Y|Y|Y|

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, the Company shall have the right to vary the benefits which may be payable and furthermore, 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
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Signature of the Insurance Advisor : _____

SECTION 41 OF THE INSURANCE ACT, 1938 - PROHIBITION OF REBATES

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.



ROYAL SUNDARAM INSURANCE

— Sundaram Finance Group —

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 | CIN:U67200TN2000PLC045611

☎ 1860 425 0000 | ✉ care@royalsundaram.in | 🌐 www.royalsundaram.in

Proposal No.

**SARAL SURAKSHA BIMA,
ROYAL SUNDARAM GENERAL INSURANCE CO. LIMITED.
PROPOSAL FORM**



ROYAL SUNDARAM INSURANCE
Sundaram Finance Group

Proposal No.

ACKNOWLEDGEMENT

Date

D	D	M	M	Y	Y	Y	Y
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We acknowledge with thanks the receipt of your insurance proposal. Please note that under the ASBA facility, an amount of Rs. _____ has been blocked in the ASBA account on _____ as per the details provided. The mere submission of this proposal or blocking of funds does not obligate us to issue a policy, which decision is and always shall be in our sole and absolute discretion. If we accept the proposal, the premium amount will be debited, and the policy will be issued subject to its terms and conditions. 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



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