Advanced Top Up Health Insurance Plan

ROYAL SUNDARAM INSURANCE
Sundaram Finance Group

URN No.: AH/2026-27/HLIP-18

PROPOSAL FORM

FOR OFFICE USE ONLY

Branch Name:_____ Branch Code:_____

Intermediary: ☐ Agency ☐ Direct ☐ Corporate Agency ☐ Other Intermediaries _____

Intermediaries 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/REPRESENTATIVE)

- 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 any one 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-fulfilment of pre-policy medical check-up.
- Please fill up this form in CAPITAL LETTERS for yourself and each proposed Insured Person.
- A policyholder or prospect who is a person with disability and requires assistance in completing the proposal form, may duly authorize a representative to give declaration on his/her behalf.

PROPOSER DETAILS

☐ Mr. ☐ Mrs. ☐ Miss ☐ Others _____ Gender ☐ Male ☐ Female ☐ Third Gender

PAN Number Aadhaar No.

Name of the Proposer
First Name Middle Name Last Name

Permanent Address
(As per address proof)

City State

Landmark Pincode

Telephone Mobile /

Current Address (if different from Permanent Address)

☐ Same as permanent address

City State

Landmark Pincode

Telephone Mobile /

Date of Birth | D | D | M | M | Y | Y | Y | Y |

Education Qualification ☐ Lesser than matriculation ☐ Matriculation ☐ Graduate ☐ Post Graduate ☐ Professional Course

Annual Gross Income (₹) ☐ Up to 5 lakhs ☐ 5 to 10 Lakhs ☐ 10 to 25 Lakhs ☐ 26 to 50 lakhs ☐ 50 Lakhs to 1 Crore ☐ Above 1 Crore

E-mail

Ayushman Bharat Health Account* (ABHA)

*Please provide ABHA number (Ayushman Bharat Health Account number) for all the proposed Insured Persons. In case the ABHA number is not available for any Insured Person, you may request to create an ABHA number by visiting the web link: https://abha.abdm.gov.in/abha/v3/register

e-IA Number (Electronic Insurance Account Number)

Would you like to open an Electronic Insurance Account with any Insurance Repository? ☐ YES ☐ NO

If yes, please furnish the below details.*

Insurance Repository Name

*Account will be opened with your Name / DOB / Address as mentioned in this proposal form.

If you already have an Electronic Insurance Account, please share the below details

Account Number

Account Name

Insurance Repository Name

Please specify if you fall under any of the listed categories. (please tick and give details where ever required)

☐ Non Resident Indian (NRI)

☐ Member of any Trust: ☐ Charities ☐ Non-Government Organisation (NGO)

☐ Politically Exposed 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.

KNOW YOUR CUSTOMER (KYC) DETAILS

Please provide your Central Know Your Customer registration number below.

CKYC Number

Marital Status ☐ Single ☐ Married ☐ Widow/Widower ☐ Divorced

Nationality ☐ Indian ☐ Foreign National

Occupation ☐ Salaried ☐ Self Employed ☐ Others:_____

Are you an existing Royal Sundaram customer?* ☐ YES ☐ NO

*If yes, please provide

Existing Policy No.

Customer ID No.

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
   ☐ Any other officially valid document (please specify) ……
4. **Identity Proof (only for those submitting Form 60)** ☐ Driving License ☐ Voter's Identity Card ☐ Passport Copy ☐ NREGA Card
   ☐ Any other officially valid document (please specify) ……

Note - Address proof and identity proof may be submitted as two separate documents or as a single document.

DETAILS OF PERSONS TO BE COVERED

Sl. No	Insured Name (First, Middle, Last)	Gender: Male (M)/Female (F)/ Third Gender (TG)	ABHA No.	Date of birth (DD/MM/YYYY)	Relationship with proposer	Height (cm)	Weight (kg)	Occupation	Annual Income (if applicable)
1.		M F TG							
2.		M F TG							
3.		M F TG							
4.		M F TG							
5.		M F TG							
6.		M F TG							

*Please choose the relationship with proposer from this list - Self/Spouse/ Dependent Child(ren)

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

COVERAGE SELECTION

1. Plan details

Policy Type: ☐ Individual ☐ Family Floater

If Family Floater*, number of persons to be covered _____Adults _____Children
(* - Max 2 Adults and 4 children)

2. Proposed policy term

Policy Tenure: ☐ 1 Year ☐ 2 Years ☐ 3 Years

3. Deductible and Sum Insured (₹) (Please Select)

Deductible	Sum Insured
5 lakhs	☐ 10 lakhs ☐ 15 lakhs ☐ 20 lakhs ☐ 45 lakhs ☐ 70 lakhs ☐ 95 lakhs
10 lakhs	☐ 15 lakhs ☐ 40 lakhs ☐ 65 lakhs ☐ 90 lakhs
15 lakhs	☐ 10 lakhs ☐ 35 lakhs ☐ 60 lakhs ☐ 85 lakhs
20 lakhs	☐ 30 lakhs ☐ 55 lakhs ☐ 80 lakhs
25 lakhs	☐ 25 lakhs ☐ 50 lakhs ☐ 75 lakhs

Please select your choice of TPA (Third Party Administrator) to service your cashless claims.

☐ Paramount Health Services (TPA) Pvt Ltd. ☐ Medi Assist Insurance TPA Pvt. Ltd

Note : The above is in compliance with F.No. IRDAI / Reg/15/166/2019.Insurance Regulatory and Development Authority of India (Third Party Administrators – Health Services) (Amendment) Regulations, 2019.

OPTIONAL COVER

1. Reduction in Pre-Existing Disease waiting period from 36 months to 24 months ☐ YES ☐ NO

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

Account Number Bank IFSC Code

Account Holder Name

Account Type ☐ Saving ☐ Current ☐ Others

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. Following section to be filled by the proposer:

Nominee Name**	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. Account Holder Name 5. Account Type (Savings/Current/Others)

Nominee Name**	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. Account Holder Name 5. Account Type (Savings/Current/Others)
		Present Address Permanent Address Phone Number Email ID		1. Account No. 2. IFSC Code 3. Bank Name 4. Account Holder Name 5. Account Type (Savings/Current/Others)
		Present Address Permanent Address Phone Number Email ID		1. Account No. 2. IFSC Code 3. Bank Name 4. Account Holder Name 5. Account Type (Savings/Current/Others)

**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

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.

MEDICAL QUESTIONS

(Yes/No response is mandatory for each of the questions. Any other response will be treated as a non-submission. You must answer these questions truthfully)

Please answer the below mentioned questions accurately to the best 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.

Please ensure that you are fully informed about the standard waiting periods and permanent exclusions that apply to this product.

Sl. No	Details	Insured 1	Insured 2	Insured 3	Insured 4	Insured 5	Insured 6
1	Have you or other family members proposed, ever suffered or are suffering from any Pre-Existing Disease (PED) (except as listed in Question 2) which have been diagnosed and for which you have been treated or taking continuous treatment or medication, Within the last 4 years, prior to this application? If 'Yes' please specify	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
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.

ADDITIONAL MEDICAL INFORMATION

If you have answered yes to any of the Health questions in Medical Questions, 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.

GENERAL INFORMATION

Please confirm if any of the persons to be insured is pregnant (applicable for females only) ☐ YES ☐ NO

FAMILY PHYSICIAN DETAILS

Family Physicians Name

Contact Number

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.					D D M M Y Y Y Y	D D M M Y Y Y Y			☐ YES ☐ NO
2.					D D M M Y Y Y Y	D D M M Y Y Y Y			☐ YES ☐ NO

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

CAUTION

You are obliged to make a complete 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

Signature of the Proposer / Representative : _____

Place : _____

Name of Proposer : _____

DECLARATION

1. 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.
2. 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.
3. 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.

4. 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.

5. 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.

6. 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.

7. 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.

8. 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.

9. 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.

10. I consent to the collection, processing and sharing of my personal data in accordance with the Digital Personal Data Protection Act, 2023 solely for underwriting, policy servicing and claims purpose.

11. 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| Signature of the Proposer/Representative : _____

Place : _____ Name of Proposer : _____

AUTHORIZATION FOR REPRESENTATIVE (for Persons With Disability Requiring Assistance)

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.

Declaration by Representative

I confirm that I have completed this proposal form on behalf of the proposer to the best of my ability and as per their instructions.

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

Contact Number of Authorized Representative: _____ Signature of Authorized Representative: _____

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

VERNACULAR DECLARATION

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

Declarants Name

Relationship with proposer

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

Place : _____ Name of Proposer : _____

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

PAYMENT DETAILS (Please tick (√) payment option)

ASBA Bank Account Details

(For blocking the premium amount under BIMA ASBA facility)

ASBA Bank Name

ASBA Bank A/c. No. IFSC/MICR Code

ASBA A/c. Holder Name
(in case Applicant is different from ASBA A/c. Holder)

OR UPI ID (Maximum 45 characters) _____Type of Account

(Savings/Current): _____

ASBA Declaration

I hereby give my consent and authorize _____ Bank to block the premium amount payable and debit the same from my account under BIMA ASBA facility upon acceptance of my proposal for Insurance by Royal Sundaram General Insurance Company.

If the ASBA bank account is held by a person other than the Proposer, I confirm that I have obtained the consent of the account holder for the blocking and debiting of the premium amount as per the terms of the BIMA ASBA facility.

Signature of the Proposer/Representative: _____ Signature of the Account Holder (if different from Proposer): _____

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 Signature of the Intermediary : _____

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.

Insurance is the subject matter of the solicitation. For more details on benefits, exclusions, risk factors, terms and conditions, please read the policy documents carefully, before concluding a sale.

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**

Advanced Top Up Health Insurance Plan

ROYAL SUNDARAM INSURANCE
Sundaram Finance Group

Proposal No.

PROPOSAL FORM

ACKNOWLEDGEMENT

Date D D M M Y Y Y Y

We acknowledge with thanks the receipt of your insurance proposal. Please note that under the ASBA facility, an amount of ₹ _____ 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 out 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 we do not accept the proposal and if the premium is not received by us in full and in time or is not realized.

Signature of the receiver and office seal

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