COMMON PROPOSAL FORM FOR HEALTH INDEMNITY PRODUCTS

ROYAL SUNDARAM INSURANCE
Sundaram Finance Group

Proposal No.

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 ☐ 3rd 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 | Marital Status: ☐ Married ☐ Single Nationality: ☐ Indian ☐ NRI ☐ Foreigner

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

Occupation ☐ Salaried ☐ Self employed ☐ Student ☐ House wife ☐ Others

If salaried, specify designation_____

If self employed, specify business/occupation_____

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)

1. ☐ Non Resident Indian (NRI)
2. ☐ Member of any Trust: ☐ Charities ☐ Non-Government Organisation (NGO)
3. ☐ 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

Occupation ☐ Service ☐ 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 can be 2 different documents or 1 same document too.

PRODUCT OPTION (please tick the product opted)

- ☐ Lifeline - UIN: RSAHLIP24146V032324
- ☐ Multiplier - UIN: RSAHLIP23030V012223
- ☐ Advanced Top Up Health Insurance Plan - UIN: RSAHLIP23029V012223
- ☐ Arogya Sanjeevani Policy - UIN: RSAHLIP25013V022425
- ☐ Family Plus - UIN: RSAHLIP22200V032122
- ☐ Health EcoAdvantage - UIN: RSAHLIP25006V012425

(Refer respective product brochures/other policy documents for details)

DETAILS OF PERSONS TO BE COVERED

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

*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, Sonin-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.

Note: Please enter the details of additional members in excess of 6 in the additional sheet attached at the end of this form.

PRODUCT SECTION (fill only those product details which the proposer wants to opt)

For Individual Plan - Kindly indicate the plan and sum insured details for all the members to be covered.

For Family Floater Plan - The plan option and sum insured will float over the family members covered under the Policy.

Policy term (Please tick the term opted) : ☐ 1 Year ☐ 2 Years ☐ 3 Years

Policy type : ☐ Floater ☐ Individual

Instalment Option (Except for Advanced Top Up Health Insurance Plan): If policy term more than one year, installment option is available.

Please tick any one option you want to opt for: ☐ Monthly ☐ Quarterly ☐ Half Yearly

LIFELINE

Plan options available: Lifeline Classic, Lifeline Supreme, Lifeline Elite.
Please provide coverage details in below table (Please do not fill anything in Premium Computation Column):

Sl. No	Insured Name (First, Last)	Individual Sum Insured Option			Floater Sum Insured Option			Premium Computation (for office use only)	Final Premium
		Plan	Sum Insured	Voluntary Deductible	Plan	Sum Insured	Voluntary Deductible		
1.									
2.									
3.									
4.									

AROGYA SANJEEVANI POLICY

Please provide coverage details in below table (Please do not fill anything in Premium Computation Column):

Sl. No	Insured Name (First, Last)	Individual Sum Insured Option	Floater Sum Insured Option	Premium Computation (for office use only)	Final Premium
1.					
2.					
3.					
4.					

MULTIPLIER

Please provide coverage details in below table (Please do not fill anything in Premium Computation Column):

Sl. No	Insured Name (First, Last)	Individual Sum Insured Option	Floater Sum Insured Option	Premium Computation (for office use only)	Final Premium
1.					
2.					
3.					
4.					

Optional Cover (Please Select)

1. ☐ ABCD Benefit (to be opted only if any of the Insured Person has ABCD illness as Pre-existing Disease)
2. ☐ Health & Wellness Plus (will be available for the 2 proposed persons only who should be above the age of 18.)
3. ☐ Hospital Plus
4. ☐ Voluntary Co-payment ☐ 5% ☐ 10% ☐ 15% ☐ 20%

FAMILY PLUS

Please provide coverage details in below table (Please do not fill anything in Premium Computation Column):

Sl. No	Insured Name (First, Last)	Individual Sum Insured Option	Floater Sum Insured Option	Premium Computation (for office use only)	Final Premium
1.					
2.					
3.					
4.					

Additional Benefit

Hospital Cash Benefit - Do you want to apply for a Hospital Cash benefit? ☐ YES ☐ NO

ADVANCED TOP UP HEALTH INSURANCE PLAN

Please provide coverage details in below table (Please do not fill anything in Premium Computation Column):

Sl. No	Insured Name (First, Last)	Individual Sum Insured Option			Floater Sum Insured Option			Premium Computation (for office use only)	Final Premium
		Plan	Sum Insured	Deductible	Plan	Sum Insured	Deductible		
1.									
2.									
3.									
4.									

Optional Cover (Please select)

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

HEALTH ECOADVANTAGE

Please provide coverage details in below table (Please do not fill anything in Premium Computation Column):

Sl. No	Insured Name (First, Last)	Individual Sum Insured Option	Floater Sum Insured Option	Premium Computation (for office use only)	Final Premium
1.					
2.					
3.					
4.					

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
		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

Health Details* (Yes/No response is mandatory for each of the questions. Any other response will be treated as a non-submission.)

Sl. No	Details	Insured 1	Insured 2	Insured 3	Insured 4	Insured 5	Insured 6
1.	Within the last 2 years have you consulted a doctor or healthcare professional? (other than Preventive Health Check-up or Pre Employment Health Check-up)	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
2.	Within the last 2 years have you underwent for any detailed investigation (e.g. X-ray, CT Scan, biopsy, MRI, Sonography, etc) (other than Preventive Health Check-up or Pre Employment Health Check-up)	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
3.	Within the last 5 years have you been to a hospital for an operation/medical treatment?	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO

Sl. No	Details	Insured 1	Insured 2	Insured 3	Insured 4	Insured 5	Insured 6
4.	Do you take tablets, medicines or drugs on a regular basis?	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
5.	Within the last 3 months have you experienced any health problems or medical conditions which you/proposed insured person have/has not seen a doctor for	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
6.	Have any of the person proposed to be insured ever suffered from or taken treatment, or hospitalized for or have been recommended to take investigations/ medication/surgery or undergone a surgery for any of the following – Diabetes; Hypertension; Ulcer/Cyst/Cancer; Cardiac Disorder; Kidney or Urinary Tract Disorder; Disorder of muscle/bone/joint; Respiratory disorder; Digestive tract or gastrointestinal disorder; Nervous System disorder; Mental Illness or disorder, HIV or AIDS	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
7.	Does any person to be insured regularly smoke Tobacco? Or consume alcohol* or any other substance like guthka / pan / pan masala or narcotics -If yes, please mention – quantity / day, number of years since (consuming/ smoking / drinking)**	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
8.	Has any of the person proposed to be insured ever suffered from or taken treatment, or hospitalized for or have been recommended to take investigations/medication for any of the following – Asthma, High Blood Pressure, High Cholesterol and Diabetes (ABCD)	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO

*Beer - Number of Pints per week, Wine & Spirit - ml/week.

**If any of these habits has been in the past, please mention the year of stopping it and the reason for doing the same - Habit.

Note: In addition to the above, we may have additional questions for you or may ask you to undergo medical tests to complete your full medical assessment.

If you have answered YES to Question No. 8, then please mention details in the additional information section below:

ABCD Table:

Sl. No	Health Condition	Criteria	Reference Values	Proposed Insured 1	Proposed Insured 2	Proposed Insured 3	Proposed Insured 4
1.	Asthma	Number of Attacks of Breathlessness/Shortness of Breath per Month	Reference normal value- 6 episodes of breathlessness per month)	_____/_____	_____/_____	_____/_____	_____/_____
2.	Blood Pressure	Latest Average Blood Pressure reading taken in the morning through any Blood pressure Monitoring Machine at Home.	(Reference normal value- 80 mm Hg/ 120 mm Hg)	_____/_____	_____/_____	_____/_____	_____/_____
3.	Cholesterol	Your latest total Serum cholesterol levels found in your blood.	(Reference – normal Value- 200 mg/dl)	_____mg/dl	_____mg/dl	_____mg/dl	_____mg/dl
4.	Diabetes	Your Latest HBA1C Value taken in the last one year	Reference – normal value – upto 6.4%	_____/_____	_____/_____	_____/_____	_____/_____

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

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	Policy No.	Name and Address of insurance company	Sum Insured	Period of insurance first inception date	From dd/mm/yy to: dd/mm/yy	Claim details, claim amount received or receivable (in ₹)	Are any persons to be insured opting for portability or migration from an existing cover? (YES/NO)
1.								
2.								
3.								
4.								
5.								

*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|

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. I am (please tick all that are applicable): ☐ HNI ☐ NRI ☐ Politically Exposed Person ☐ Jeweller ☐ NGO ☐ Film Actor ☐ Producer ☐ Others.
9. 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.

10. 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.

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.

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

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

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.

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

Branch Name

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 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**

COMMON PROPOSAL FORM FOR HEALTH INDEMNITY PRODUCTS

ROYAL SUNDARAM INSURANCE
Sundaram Finance Group

Proposal No.

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 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 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 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 payment, if any, received from you without interest.

Signature of the receiver and office seal

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