ZURICH kotak
General Insurance

ZK - 25-26/v1

Group Smart Health Proposal Form

PGSH

GUIDELINES FOR COMPLETION OF THE PROPOSAL FORM

1. Please fill the proposal form in BLOCK LETTERS. All details with * are mandatory.
2. The issuance of this form by Zurich Kotak General Insurance Company (India) Limited (hereafter referred as "Company") does not amount to acceptance of the proposal. The Liability of the Company in relation to the subject matter of this Proposal does not commence until this Proposal has been accepted by the Company through the issuance of the Policy Document/Cover Note and subject to the receipt by the Company of the premium paid.
3. This Proposal will be the basis of any subsequent policy that the Company issues to you. It is therefore essential that you provide all the information in this Proposal FULLY, ACCURATELY AND CORRECTLY in respect of all persons proposed to be insured and that you provide the Company with any and all additional information relevant to risk to be insured or the Company's decision as to acceptance of the risk or the terms upon which it should be accepted.
4. The Policy shall become voidable at the option of the Company, in the event of any untrue or incorrect or incomplete statement, misrepresentation, non-description or on 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 proposed policyholder or any one acting on its behalf to obtain any benefit under this Policy.
5. If you require additional space to answer any question on this Proposal Form, please attach additional sheets of paper and indicate on the additional sheet the question number to which the information being provided pertains. (Information given herein will be treated in strict confidence).

FOR OFFICE USE ONLY

Quote No.*	Quote Date*	Branch Code	Sales Manager Code	Intermediary Code	Intermediary Service RM	Intermediary Branch code	Intermediary business vertical	Intermediary Client Ref. No.	SP Name/Code

PROPOSER'S INFORMATION

Name of the Proposer/ Group Administrator/ Bank/ Financial Institution (Organisation/ Institute/ Association)*

Proposer's Trade/ Business/ Activity*

Proposer's Registered Office Address*

Address (Line 1)

Address (Line 2) Nearest Landmark

City / District State Pin Code Country

Is the Mailing Address same as the Registered Office Address?* ☐ Yes ☐ No If 'No', please provide below

Proposer's Mailing Address*

Address (Line 1)

Address (Line 2) Nearest Landmark

City / District State Pin Code Country

Contact No.* Mobile No.* Email ID*

GSTIN CKYC Identifier / Number (Generated by CERSAI):

PAN*:

Please share the below details for the Authorised Signatory:

Name: Designation:

CKYC Identifier / Number (Generated by CERSAI):

Any existing policy from Us ☐ Yes ☐ No If 'Yes', Policy No

COVERAGE DETAILS (*)

1. Policy Period: From: D D M M Y Y Y Y To: Midnight of D D M M Y Y Y Y
2. Policy Tenure: Year(s)/ Month(s) Day(s) Hour(s)
3. Policy Category: Individual/ Family Floater
4. Number of Persons to be insured

Categories of proposed Insured (Add more categories if needed) – (senior management, middle management, management trainee, etc)

a. Cat 1:

b. Cat 2:

c. Cat 3:

d. Cat 4:

e. Cat 5:

5. Family Definition:

6. Relationships Covered:

7. Type of Credit (#)

8. Installment Option* ☐ Yes ☐ No If yes, Installment Frequency*: ☐ Monthly ☐ Quarterly ☐ Half yearly

(#) Applicable only to credit linked policies

BENEFIT DETAILS (*)

Please Tick on the Benefit You want to opt for

Sr. No.	Covers	Tick on Cover You want to opt	Sum Insured/ Daily Cash Amount	Additional Details	Remarks (Deductible/ Co-pay as applicable)
SECTION A - PERSONAL ACCIDENT BENEFIT					
I.	**BASIC BENEFITS**				
1.	Accidental Death Benefit	☐ Yes ☐ No	INR ____	NA	
2.	Permanent Total Disablement (PTD) Benefit	☐ Yes ☐ No	INR ____	NA	
3.	Permanent Partial Disablement (PPD) Benefit	☐ Yes ☐ No	INR ____	NA	
4.	Temporary Total Disablement (TTD) Benefit	☐ Yes ☐ No	INR ____ per week, for ___ weeks	NA	
5.	Common Carrier Accident Benefit (Accidental Death)	☐ Yes ☐ No	INR ____	NA	
6.	Common Carrier Accident Benefit (PTD)	☐ Yes ☐ No	INR ____	NA	
7.	Accidental Hospitalisation (Inpatient)	☐ Yes ☐ No	INR ____	NA	
8.	Burns Benefit	☐ Yes ☐ No	INR ____	NA	
9.	Broken Bones Benefit	☐ Yes ☐ No	INR ____	NA	
10.	Convalescence Benefit (due to Accident)	☐ Yes ☐ No	INR ____	Payable on hospitalisation for a minimum of ____ consecutive days	
II.	**OPTIONAL BENEFITS**				
11.	Carriage of Dead Body	☐ Yes ☐ No	INR ____	NA	
12.	Funeral Expenses	☐ Yes ☐ No	INR ____	NA	
13.	Accidental Medical Expenses Extension	☐ Yes ☐ No	INR ____	NA	
14.	Purchase of Blood	☐ Yes ☐ No	INR ____	NA	
15.	Transportation of imported medicine	☐ Yes ☐ No	INR ____	NA	
16.	Modification of Residence / Vehicle	☐ Yes ☐ No	INR ____	NA	
17.	Cost of Support Items	☐ Yes ☐ No	INR ____	NA	
18.	Children Education Benefit	☐ Yes ☐ No	INR ____	NA	
19.	Marriage expenses for Children	☐ Yes ☐ No	INR ____	NA	
20.	Widowhood Cover	☐ Yes ☐ No	INR ____	NA	
21.	Ambulance Charges (Accidental Hospitalisation)	☐ Yes ☐ No	INR ____	NA	
22.	Accidental Pre & Post Hospitalization Expenses Benefit	☐ Yes ☐ No	INR ____	Pre-hospitalisation – ____ days Post-hospitalisation – ____ days	
23.	Domestic travel for medical treatment due to accident	☐ Yes ☐ No	INR ____	NA	
24.	On Duty Cover	☐ Yes ☐ No			
25.	Legal Expenses	☐ Yes ☐ No	INR ____	NA	
26.	Dental Expenses due to Accident	☐ Yes ☐ No	INR ____	NA	
27.	Coma Benefit (due to Accident)	☐ Yes ☐ No	INR ____	NA	
28.	Child Care Benefit	☐ Yes ☐ No	INR ____	NA	
29.	Parental Care Benefit	☐ Yes ☐ No	INR ____	NA	
30.	Counselling Benefit	☐ Yes ☐ No	INR ____	NA	
31.	Repatriation in case of Permanent Total Disablement	☐ Yes ☐ No	INR ____	NA	
32.	Air Ambulance (Accident Related)	☐ Yes ☐ No	INR ____	NA	
33.	Assault Cover	☐ Yes ☐ No	INR ____	NA	
34.	Sports Activity Cover	☐ Yes ☐ No	INR ____	NA	

SECTION B - ANIMAL, INSECT AND REPTILE ATTACK BENEFIT					
1.	Death due to Animal, Insect and Reptile Attack Benefit	☐ Yes ☐ No	INR ____	NA	
2.	Permanent Total Disablement due to Animal, Insect and Reptile Attack Benefit	☐ Yes ☐ No	INR ____	NA	
3.	Permanent Partial Disablement due to Animal, Insect and Reptile Attack Benefit	☐ Yes ☐ No	INR ____	NA	
4.	Hospitalisation Expenses due to Animal, Insect and Reptile Attack Reimbursement Benefit	☐ Yes ☐ No	INR ____	NA	
5.	Hospital Daily Cash Benefit for Animal, Insect and Reptile Attack	☐ Yes ☐ No	INR ____ per day for ___ no. of days	NA	Deductible ☐ Franchise ☐ No of day(s) _____
6.	OPD Benefit for Animal, Insect and Reptile Attack	☐ Yes ☐ No	INR ____	NA	
7.	Convalescence Benefit for Animal, Insect and Reptile Attack	☐ Yes ☐ No	INR ____	Payable on hospitalisation for a minimum of ____ consecutive days	
SECTION C - SPECIFIC VECTOR BORNE DISEASE BENEFIT					
1.	Specific Vector Borne Disease related Fixed Benefit	☐ Yes ☐ No	INR ____	NA	
2.	Specific Vector Borne Disease related Hospitalisation Benefit	☐ Yes ☐ No	INR ____	NA	
3.	Hospital Daily Cash Benefit for Specific Vector Borne Disease	☐ Yes ☐ No	INR ____ per day for ___ no. of days	NA	Deductible ☐ Franchise ☐ No of day(s) _____
4.	OPD Benefit for Specific Vector Borne Disease	☐ Yes ☐ No	INR ____	NA	
5.	Convalescence Benefit for Specific Vector Borne Disease	☐ Yes ☐ No	INR ____	Payable on hospitalisation for a minimum of ____ consecutive days	
SECTION D - SPECIFIC COMMUNICABLE DISEASE BENEFIT					
1.	Specific Communicable Disease related Fixed Benefit	☐ Yes ☐ No	INR ____	NA	
2.	Specific Communicable Disease related Hospitalisation Benefit	☐ Yes ☐ No	Upto INR ____	NA	
3.	Hospital Daily Cash Benefit for Specific Communicable Disease	☐ Yes ☐ No	INR XX per day for ___ no. of days	NA	Deductible ☐ Franchise ☐ No of day(s) _____
4.	OPD Benefit for Specific Communicable Disease	☐ Yes ☐ No	INR ____	NA	
5.	Convalescence Benefit for Specific Communicable Disease	☐ Yes ☐ No	INR ____	Payable on hospitalisation for a minimum of ____ consecutive days	
SECTION E - HOSPITAL DAILY CASH BENEFIT					
I.	**BASIC BENEFITS**				
1.	Hospital Daily Cash Benefit	☐ Yes ☐ No	INR ____ per day for ___ no. of days	NA	Deductible ☐ Franchise ☐ No of day(s) _____
2.	Accident Daily Cash Benefit	☐ Yes ☐ No	INR ____ per day for ___ no. of days	NA	Deductible ☐ Franchise ☐ No of day(s) _____
3.	ICU Daily Cash Benefit	☐ Yes ☐ No	INR ____ per day for ___ no. of days	NA	Deductible ☐ Franchise ☐
II.	**OPTIONAL BENEFITS**				No of day(s) _____
4.	Companion Benefit	☐ Yes ☐ No	INR ____ per day for ___ no. of days	NA	
5.	Joint Hospitalisation	☐ Yes ☐ No	INR XX	NA	
6.	Parent Accommodation	☐ Yes ☐ No	INR ____ per day for ___ no. of days	NA	
7.	Maternity Benefit	☐ Yes ☐ No	INR ____ per day for ___ no. of days	NA	
8.	New Born Baby Benefit	☐ Yes ☐ No	INR ____ per day for ___ no. of days	NA	
9.	Worldwide Cover	☐ Yes ☐ No			
SECTION F - CRITICAL ILLNESS BENEFIT					
1.	Specific Critical Illness Benefit	☐ Yes ☐ No	INR ____		
2.	Critical Illness Daily Cash Benefit	☐ Yes ☐ No	INR ____ per day for ___ no. of days	NA	Deductible ☐ Franchise ☐ No of day(s) _____

3.	CI Related Hospitalisation Benefit	☐ Yes ☐ No	INR ____	NA	
4.	Critical Illness OPD Benefit	☐ Yes ☐ No	INR ____	NA	
SECTION G - LOSS OF JOB BENEFIT					
1.	Loss of Job Benefit due to Accident	☐ Yes ☐ No	INR ____ per month	No of months |__|	
2.	Loss of Job Benefit due to Critical Illness	☐ Yes ☐ No	INR ____ per month	No of months |__|	
3.	Loss of Job Benefit due to Illness/ Injury	☐ Yes ☐ No	INR ____ per month	No of months |__|	
SECTION H - RECURRING PAYOUT BENEFIT					
1.	Recurring Payout Benefit due to Accident	☐ Yes ☐ No	INR ____ (EMI amount)	No of EMIs |__|	
2.	Recurring Payout Benefit due to Critical Illness	☐ Yes ☐ No	INR ____ (EMI amount)	No of EMIs |__|	
3.	Recurring Payout Benefit due to Illness/ Injury	☐ Yes ☐ No	INR ____ (EMI amount)	No of EMIs |__|	
SECTION I - OPD BENEFIT					
1.	OPD Expenses	☐ Yes ☐ No	INR ____	NA	
2.	OPD Dental Treatment	☐ Yes ☐ No	INR ____	NA	
3.	OPD Vision Treatment	☐ Yes ☐ No	INR ____	NA	
4.	OPD AYUSH Treatment Expenses	☐ Yes ☐ No	INR ____	NA	
5.	OPD Accident Treatment Expenses	☐ Yes ☐ No	INR ____	NA	
SECTION J - SURGERY BENEFIT					
1.	Day Care Procedure Benefit	☐ Yes ☐ No	INR ____	NA	
2.	Surgery Benefit	☐ Yes ☐ No	INR ____ (EMI amount)	No of EMIs |__|	
SECTION K - MATERNITY COMPLICATION BENEFIT					
	Maternity Complication Benefit	☐ Yes ☐ No	INR ____		
SECTION L - HEALTH AND WELLLNESS BENEFIT					
	Wellness Program	☐ Yes ☐ No	Please specify details:		
SECTION M - OTHER BENEFITS					
1.	Compassionate Visit Benefit	☐ Yes ☐ No	INR ____	NA	
2.	Repatriation of Mortal Remains	☐ Yes ☐ No	INR ____	NA	
3.	Convalescence Benefit	☐ Yes ☐ No	INR ____	Payable on hospitalisation for a minimum of ____ consecutive days	

Please specify the waiting period for the below mentioned exclusions:

1. Pre-existing Disease waiting period – ☐ months
2. Specified disease/ procedure waiting period – ☐ months
3. Maternity Benefit Waiting Period – ☐ months

Please specify if You would like to waive off the 30 Day Waiting Period - ☐ Yes ☐ No

INSURED DETAILS (*All fields are mandatory)

Membership ID/ Employee Number/ Account Number pertaining to Credit (#)	Name of the Financier (#)	Credit Tenure (#)	Name of the Insured Person	Category	Applicant / Co-applicant (#)	Date of Birth DD/MM /YYYY	Gender	Credit sanctioned date (#)	Credit Amount / outstanding credit amount (#)	Relationship with the Insured Person	Designation/ Occupation	Any existing illness

(#) Applicable only to credit linked policies

Nominee Details

Insured Name*	Nominee Name*	Relationship of Nominee with Proposer*	Nominee Date of Birth DD/MM/YYYY*	Nominee Mobile Number	Nominee Email ID	Nominee Present Address	Nominee Permanent Address	Nominee Bank Name and Account Details	% of claim share*
	Nominee 1								
	Nominee 1								
	Nominee 1								
	Nominee 1								
	Nominee 1								

***Total % share cannot exceed more than 100%**

Where Nominee is a minor, give details of Appointee

Name of the Nominee	Name of the Appointee	Date of Birth DD/MM/YYYY	Relationship with the Nominee

Note: Please provide an additional sheet in case of more than 1 nominee.

PREVIOUS POLICY DETAILS

Kindly provide the particulars for the past 3 policy periods or lesser period for which policy availed, in the following format.

Policy Period From – To (Rs.)	Name of the Insurer	Policy number	Number of members covered	Total premium (Rs.)	Total amount of claims (Paid + Outstanding)

*PAYMENT DETAILS

☐ Cheque ☐ Demand Draft ☐ Credit Card ☐ Online Payment

Cheque / D.D # Amount Drawn On

Date D D M M Y Y Y Y Bank

Branch (In favour of Zurich Kotak General Insurance Company (India) Limited.)

IFSC/MICR Code

For Credit / Debit Card

Transaction Reference No. Transaction Date D D M M Y Y Y Y

Online / Credit card premium payment should be made by the policyholder himself. Third party payments are not allowed.

ACKNOWLEDGEMENT

Received from M/s a sum of Rs.

Through Cheque/DD against your proposal for Group Smart Health

Signature of Zurich Kotak General Insurance Company (India) Limited/ Intermediary

Date D D M M Y Y Y Y

Zurich Kotak General Insurance Company (India) Limited/Intermediary Name:

Time: Place:

Note: Neither the submission of a completed proposal for insurance or any payment for any policy sought oblige the Company to agree to issue a policy, which decision is and always shall be in the Company's sole and absolute discretion. If Zurich Kotak General Insurance Company (India) Limited accepts a proposal for insurance, it shall be subject to the Board approved underwriting policy of Zurich Kotak General Insurance Company (India) Limited and the policy Terms and Conditions of Group Smart Health and the Company shall have no liability to make any payment if premium is not received by Zurich Kotak General Insurance Company (India) Limited in full and in time, or is not realised. If a proposal is not accepted, Zurich Kotak General Insurance Company (India) Limited will inform you and refund any payment received from you without interest within 15 days from the date of receipt of the proposal.

BANK ACCOUNT DETAILS

Details required to process all payment due in relation to your policy including refunds (if any) and / or claims directly to your bank account.
Please select any one of the below options as applicable.

☐ Bank details as per premium cheque to be used for electronic fund transfer ☐ **No existing Bank Account#** ☐ Cancelled Cheque submitted of Other Bank

I agree to open a bank account and provide my bank account details to the Company for electronic fund transfer as mode of payment. I shall provide these details before renewal of my insurance policy or before any payment becomes due in relation to my insurance policy (whichever is earlier). I understand that as per regulatory requirement, Company shall process any payment in relation to my insurance policy only through electronic fund transfer after receipt of aforesaid pending bank details from me.

Particulars of Bank Account:

Bank Name _____ Account Holder Name _____

Account No. _____ IFSC/MICR Code _____

Disclaimer: Zurich Kotak General Insurance Company (India) Limited shall not be liable to anybody, in any manner, whatsoever if the NEFT transaction does not complete

ASBA Declaration:

☐ I hereby accord my consent to authorize Zurich Kotak General Insurance to block the applicable premium payable for the aforesaid insurance policy under the BIMA ASBA facility and debit the same from my bank account upon acceptance of this proposal. In case the proposal is not accepted, I accord my consent to debit only the expenses incurred towards medical examination, if any, and unblock the balance amount.

Place* _____ Date* _____ *Signature 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.

Protect and contribute in conserving the environment, all your policy and service related communication would be sent in soft copy to the email id mentioned in the proposal form and it is valid for all regulatory /policy servicing requirements. ☐ I / We would still want to receive a physical copy of the policy.

☐ I/we hereby give my/our consent to the Company to verify and obtain my/our identity/address proof through Central KYC Registry or Goods and Service Tax Portal or Ministry of Corporate Affairs Portal or National Securities Depository Limited portal for the purpose of undertaking KYC.

☐ I/We hereby agree for sharing my/our medical records with the Insurer/ TPA through ABHA number mentioned in the proposal form. (Applicable for cases wherein ABHA number is available)

AML Declaration:

I / We hereby confirm that all premiums have been/will be paid from bonafide sources and no premiums have been /will be paid out of proceeds of crime related to any of the offence listed in Prevention of Money Laundering Act,2002. I / We understand that the Company has the right to call for document to establish sources of funds. The Insurance Company has right to cancel the insurance contract in case I am/have been found guilty by any competent court of law under any of the statutes, directly or indirectly governing the prevention of money laundering in India. In case of entity, Type of Organisation making the payment:

☐ Limited Company ☐ Government Organisation ☐ Non-Government Organisation (NGO) ☐ Society ☐ Trust ☐ Partnership

☐ International Organisation ☐ Co-operatives ☐ Section 25 Company ☐ Others

Are You or any of the proposed applicants or close relatives is/are associated to Politically Exposed Person (PEP)?* ☐ Yes ☐ No

"Politically Exposed Persons" (PEPs) are individuals who have been entrusted with prominent public functions by a foreign country, including the heads of States or Governments, senior politicians, senior government or judicial or military officers, senior executives of state-owned corporations and important political party officials.

Are you a Non-Profit Organization?* (only in case of an entity) ☐ Yes ☐ No

"Non-profit organization" means any entity or organisation, constituted for religious or charitable purposes referred to in clause (15) of section 2 of the Income-tax Act, 1961 (43 of 1961), that is registered as a trust or a society under the Societies Registration Act, 1860 (21 of 1860) or any similar State legislation or a Company registered under the section 8 of the Companies Act, 2013 (18 of 2013).

Place* _____ Date* _____ Signature / Thumb Impression of Proposer*

VERNACULAR DECLARATION

I hereby declare that, I have fully explained the contents of the proposal form and terms and conditions of the Policy to the Proposer in the language understood to him/her and that the Proposer has affixed the thumb impression / signature after fully understanding the contents thereof.

Signature/Thumb impression of Proposer

Place* _____ Date* _____ Signature of Intermediary/Sales Person*

DECLARATION IN CASE THE PROPOSER/ POLICYHOLDER IS PERSON WITH DISABILITY (PWD)

I hereby declare that I _____ , am a person with a disability and require assistance in completing this proposal form. I authorize _____ [Name of Representative], to act as my authorized representative and provide necessary declaration on my behalf for this Insurance Policy.

Signature/Thumb impression of Proposer

Place* Date* Signature of Authorised Representative*

DECLARATION FOR AGENT

I hereby declare that, I have fully explained the features and terms & condition of the policy in detail to the Proposer and the Proposer has affixed the thumb impression / signature after fully understanding the features thereof.

Signature / Stamp of the Proposer*

Place* Date*

Signature & Stamp as applicable of the Insurance Advisor/Specified person of Corporate Agent/Authorised Employee of Broker/Sales person*

STATUTORY WARNING

PROHIBITION OF REBATES (Under Section 41 of Insurance Act 1938 as amended)

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 renewing or continuing a Policy accept any rebate, except such rebate as may be allowed in accordance with the published prospectuses or tables of the Insurer.

2) Any person making default in complying with the provisions of this section shall be punishable with fine, which may extend to Ten Lakhs Rupees.

Zurich Kotak General Insurance Company (India) Limited
(Formerly known as Kotak Mahindra General Insurance Company Limited)
CIN: U66000MH2014PLC260291. IRDAI Reg. No. 152. Registered & Corporate Office: 401, 4th Floor, Silver Metropolis, Jai Coach Compound, Off Western Express Highway, Goregaon (East), Mumbai - 400063. Maharashtra, India. Toll free: 1800 266 4545; Email: care@zurichkotak.com; Website: www.zurichkotak.com