

ZK - 25-26/v1

Health Assure Proposal Form

HAPP

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 / OWNER'S DETAILS

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 Pin Code State 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 Pin Code State 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: To: Midnight of
2. Policy Category: Individual/ Family Floater
3. 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:
4. Family Definition:
 5. Relationships Covered:
 6. Type of Credit (#)
 7. Installment Option* Yes No If yes, Installment Frequency*: Monthly Quarterly Half yearly

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

- Family Health Plan Insurance TPA Ltd. Paramount Health Services & Insurance TPA Pvt. Ltd. Medi Assist Insurance TPA Pvt. Ltd.

(#) Applicable only to credit linked policies

PUT A (✓) TICK MARK WHEREVER APPLICABLE:

Please Tick on the Benefit You want to opt for

Sr. No.	Base Covers	Sum Insured Limits					
		Cat 1	Cat 2	Cat 3	Cat 4	Cat 5	
(i)	In-patient Treatment						
(ii)	Pre-Hospitalisation Medical Expenses						
(iii)	Post-Hospitalisation Medical Expenses						
(iv)	Day Care Treatment						
(v)	Domiciliary Hospitalisation						
(vi)	Emergency Ambulance						
(vii)	Donor Expenses						
(viii)	AYUSH Treatment						
Sr. No.	Optional Covers	Tick on Cover You want to opt	Sum Insured/ Daily Cash Amount				
			Cat 1	Cat 2	Cat 3	Cat 4	Cat 5
(I)	Air Ambulance	<input type="checkbox"/> Yes <input type="checkbox"/> No					
(ii)	Hospital Daily Cash Benefit	<input type="checkbox"/> Yes <input type="checkbox"/> No					
	Daily Cash Amount		Rs._____ per day				
	Maximum No. of Days		_____ days				
-	Deductible / Franchise		Deductible <input type="checkbox"/> - _____ days or Franchise <input type="checkbox"/> - _____ days	Deductible <input type="checkbox"/> - _____ days or Franchise <input type="checkbox"/> - _____ days	Deductible <input type="checkbox"/> - _____ days or Franchise <input type="checkbox"/> - _____ days	Deductible <input type="checkbox"/> - _____ days or Franchise <input type="checkbox"/> - _____ days	Deductible <input type="checkbox"/> - _____ days or Franchise <input type="checkbox"/> - _____ days
(iii)	ICU Daily Cash Benefit	<input type="checkbox"/> Yes <input type="checkbox"/> No					
	Daily Cash Amount		Rs._____ per day				
	Maximum No. of Days		_____ days				
-	Deductible / Franchise		Deductible <input type="checkbox"/> - _____ days or Franchise <input type="checkbox"/> - _____ days	Deductible <input type="checkbox"/> - _____ days or Franchise <input type="checkbox"/> - _____ days	Deductible <input type="checkbox"/> - _____ days or Franchise <input type="checkbox"/> - _____ days	Deductible <input type="checkbox"/> - _____ days or Franchise <input type="checkbox"/> - _____ days	Deductible <input type="checkbox"/> - _____ days or Franchise <input type="checkbox"/> - _____ days
(iv)	Convalescence Benefit	<input type="checkbox"/> Yes <input type="checkbox"/> No					
(v)	Cover for Non-Medical Expenses	<input type="checkbox"/> Yes <input type="checkbox"/> No					
(vi)	Maternity Benefit	<input type="checkbox"/> Yes <input type="checkbox"/> No					
(vii)	New Born Baby Cover	<input type="checkbox"/> Yes <input type="checkbox"/> No					
(viii)	Pre and Post Natal Care	<input type="checkbox"/> Yes <input type="checkbox"/> No					

Sr. No.	Optional Covers	Tick on Cover You want to opt	Sum Insured/ Daily Cash Amount				
			Cat 1	Cat 2	Cat 3	Cat 4	Cat 5
(ix)	Cumulative Bonus	<input type="checkbox"/> Yes <input type="checkbox"/> No	___% per year; ___% maximum limit				
(x)	Wellness Program	<input type="checkbox"/> Yes <input type="checkbox"/> No					
(xi)	Floater Cover	<input type="checkbox"/> Yes <input type="checkbox"/> No					
(xii)	Corporate Buffer	<input type="checkbox"/> Yes <input type="checkbox"/> No					
(xiii)	Room Rent Capping with proportionate deduction	<input type="checkbox"/> Yes <input type="checkbox"/> No					
(xiv)	Room Rent Capping without proportionate deductions	<input type="checkbox"/> Yes <input type="checkbox"/> No					
(xv)	Deductible	<input type="checkbox"/> Yes <input type="checkbox"/> No					
(xvi)	Co-payment	<input type="checkbox"/> Yes <input type="checkbox"/> No					
(xvii)	Disease-wise sublimit	<input type="checkbox"/> Yes <input type="checkbox"/> No					
Prime UIN- ZUKHLGA25064V012425							
A	Unlimited Reset Benefit	<input type="checkbox"/> Yes <input type="checkbox"/> No	Details:	Details:	Details:	Details:	Details:
B	Loyalty Bonus (This cover cannot be opted if Cumulative Bonus is opted in the Base policy)	<input type="checkbox"/> Yes <input type="checkbox"/> No	Details:	Details:	Details:	Details:	Details:
C	Inflation Protect	<input type="checkbox"/> Yes <input type="checkbox"/> No	Details:	Details:	Details:	Details:	Details:
D	Reduction in PED waiting Period	<input type="checkbox"/> Yes <input type="checkbox"/> No	i. 30 Days <input type="checkbox"/>				
			ii. 60 Days <input type="checkbox"/>				
			iii. 90 Days <input type="checkbox"/>				
E	Well-Being Benefits (This cover cannot be opted if covers under wellness program are opted. Refer to policy wordings for complete list)	<input type="checkbox"/> Yes <input type="checkbox"/> No	Details:	Details:	Details:	Details:	Details:
F	Annual Health Check-up (This benefit cannot be opted if already covered in the Base Policy.)	<input type="checkbox"/> Yes <input type="checkbox"/> No	Details:	Details:	Details:	Details:	Details:
G	Air Ambulance + (This benefit cannot be opted if Air Ambulance Cover opted in the Base Policy)	<input type="checkbox"/> Yes <input type="checkbox"/> No					
H	Emergency Ambulance +	<input type="checkbox"/> Yes <input type="checkbox"/> No					
I	Maternity Cover & its complications (This benefit cannot be opted if Maternity Benefit opted in the Base Policy)	<input type="checkbox"/> Yes <input type="checkbox"/> No	1. Maternity Sum Insured:				
			Normal Delivery <input type="checkbox"/>				
			Sum Insured-				
			Cesarean Section <input type="checkbox"/>				
			Sum Insured-				
			Pre and Post Natal <input type="checkbox"/>				
			Sum Insured-				
			Stem cell Preservation <input type="checkbox"/>				
Sum Insured-	Sum Insured-	Sum Insured-	Sum Insured-	Sum Insured-			

Sr. No.	Optional Covers	Tick on Cover You want to opt	Sum Insured/ Daily Cash Amount				
			Cat 1	Cat 2	Cat 3	Cat 4	Cat 5
			Infertility Treatment <input type="checkbox"/>				
			Sum Insured-				
			Maternity Complications <input type="checkbox"/>				
			Sum Insured-				
			2. Waiting periods options:				
			i. Day 1 <input type="checkbox"/>				
			ii. 9 months <input type="checkbox"/>				
			iii. 1 year <input type="checkbox"/>				
			iv. 2 years <input type="checkbox"/>				
J	New-Born Baby Cover + (This benefit cannot be opted if New Born Baby Cover opted in the Base Policy)	<input type="checkbox"/> Yes <input type="checkbox"/> No					
K	Daily Cash for Accompanying an Insured Child	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sum Insured-				
			No of Days of Hospitalization:				
			Deductible (in days):				
L	Compassionate Visit	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sum Insured-				
			Deductible (in days):				
M	Double Cover	<input type="checkbox"/> Yes <input type="checkbox"/> No	Details:	Details:	Details:	Details:	Details:
N	Cash Bag	<input type="checkbox"/> Yes <input type="checkbox"/> No					
O	Chronic Care	<input type="checkbox"/> Yes <input type="checkbox"/> No	Details:	Details:	Details:	Details:	Details:
P	Durable Medical Equipment Cover	<input type="checkbox"/> Yes <input type="checkbox"/> No	Details:	Details:	Details:	Details:	Details:
Q	Value Added Services	<input type="checkbox"/> Yes <input type="checkbox"/> No					
R	Day Care Treatment +	<input type="checkbox"/> Yes <input type="checkbox"/> No					
S	Personal Accident Cover (TTD can be opted along with either AD, PTD, PPD)	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sum Insured-				
			Accidental Death <input type="checkbox"/>				
			Permanent Total Disablement (PTD) <input type="checkbox"/>				
			Permanent Partial Disablement (PPD) <input type="checkbox"/>				
			Temporary Total Disablement (TTD) <input type="checkbox"/>				

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

* This cover cannot be opted if opted under Prime

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

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

Cheque / D.D #
 Amount
 Drawn On
 Date

Bank
 Branch
 IFSC/MICR Code

For Credit/Debit Card
 Transaction Reference No.
 Transaction Date

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/Thumb impression of 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.