ZURICH kotak
General Insurance

ZK - 25-26/v1

Medishield Proposal Form

MSPS

GUIDELINES FOR COMPLETION OF THE FORM

1. This policy is specially designed for Persons with Disability, Mental Illness and Persons with HIV/AIDS.
   a. Persons with Disability shall be covered if 40% or more disability is certified by the Medical Board appointed by the government for certifying Disability as per the Disability Act 2016.
2. Please answer all questions correctly and completely.
3. Information for fields marked with asterisk (*) are mandatory.
4. Only Indian Nationals can be covered under this policy.
5. Only one policy can be purchased for this product across all insurers.
6. Note: The Coverage proposed for insurance is not covered until the proposal is accepted and premium is paid and the same is realized by Zurich Kotak General Insurance Company (India) Limited.

INTERMEDIARY DETAILS

Intermediary Name

Intermediary Code

Intermediary Contact Details

PROPOSER DETAILS *

Title Mr. / Miss / Mrs. / M/s / Others

Name*

First Name | Middle Name | Last Name

Gender* ☐ Male ☐ Female ☐ Others Date of Birth*

Nationality* ☐ Indian ☐ Non-Indian ☐ NRI Marital Status ☐ Single ☐ Married ☐ Others

Permanent Address*

Address (Line 1)

Address (Line 2)

Nearest Landmark City / District

State Pin Code Country

Is Correspondence Address same as Permanent Address?* ☐ Yes ☐ No If 'No', please provide below

Correspondence Address*

Address (Line 1)

Address (Line 2)

Nearest Landmark City/District State

Pin Code Country GSTIN

Phone Mobile* Email*

Occupation* ☐ Business ☐ Salaried ☐ Professionals ☐ Student ☐ Housewife ☐ Retired ☐ Others

Profession* ☐ CA ☐ Paramilitary Services ☐ Govt. Teacher ☐ Govt. Employee ☐ Medical Doctor ☐ Others

Annual Income ☐ Upto 2.5 lacs ☐ 2.5 - 6 lacs ☐ 6 - 10 lacs ☐ 10 - 15 lacs ☐ 15 - 20 lacs ☐ 20 - 25 lacs ☐ >25 lacs

PAN Number* / Form 60 (only in case the customer does not have PAN No.)

CKYC Identifier / Number (Generated by CERSAI)

Please share the following for authentication purpose:

Proof of Identity (POI) and Proof of Address (POA) [Tick (✓) whichever is applicable]

☐ PAN ☐ Ration Card ☐ Passport ☐ Driving Licence ☐ Voter ID Card ☐ Others (Please specify): _____

Are you an existing customer of Kotak Mahindra Bank Ltd. / Kotak Mahindra Prime Ltd.? ☐ Yes ☐ No If Yes, CRN

Zurich / Kotak Group Employees ☐ Yes ☐ No If yes, Employee ID Any existing policy from Us ☐ Yes ☐ No If yes, Policy No.

COVERAGE DETAILS

Policy Type Individual Basis

Policy period 1 year

Period of Insurance From to

Sum Insured 4000000 ☐ 5000000 ☐

Coverage opted: Pre-existing HIV/AIDS ☐ Pre-existing Disability ☐ Pre-existing HIV/AIDS and Disability ☐

Waiver of Co-payment opted Yes ☐ No ☐

DETAILS OF PERSONS TO BE INSURED

Sr. No.	Name of the Insured	Nationality	Date of Birth	Age	Gender	Height	Weight	Occupation	Marital Status	Relation with Proposer	ABHA Number

In case your ABHA Number is not created, please visit the link (https://healthid.ndhm.gov.in/) to create the same.

Nominee Details

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*				

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

For all other persons covered under the policy, the Proposer will be the nominee.

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 if space is not sufficient to complete details.

PREVIOUS/ EXISTING HEALTH DETAILS OF INSURED

Do you suffer from HIV/AIDS?	Yes ☐ No ☐	If Yes, please enclose a recent certificate of your current CD4 count (within past 30 days)
Current CD 4 count		
Has your CD4 Count gone below 500 in the past 4 years?	Yes ☐ No ☐	If yes when and How many times
Do you suffer from any other illness/ disease related to/ arising of/ associated to HIV/AIDS?	Yes ☐ No ☐	If Yes, please give details:
Do you suffer from any disability as per the listed conditions mentioned below:	Yes ☐ No ☐	If Yes, please enclose Disability certificate mentioning percentage of disability wherever applicable.

1. Blindness ☐	2. Muscular Dystrophy ☐
3. Low vision ☐	4. Chronic Neurological conditions ☐
5. Leprosy Cured persons ☐	6. Specific Learning Disabilities ☐
7. Hearing Impairment (deaf and hard of hearing) ☐	8. Multiple Sclerosis ☐
9. Locomotor Disability ☐	10. Speech and Language disability ☐
11. Dwarfism ☐	12. Thalassemia ☐
13. Intellectual Disability ☐	14. Haemophilia ☐
15. Mental Illness ☐	16. Sickle Cell disease ☐
17. Autism spectrum disorder ☐	18. Multiple Disabilities including deaf/ blindness ☐
19. Cerebral Palsy ☐	20. Acid Attack victim ☐
21. Parkinson's disease ☐	

Do you suffer from any pre-existing illness other than Disability or HIV AIDS mentioned above? Yes ☐ No ☐

If Yes, please specify details and the number of years you are suffering:

Do you have any other physical disability arising out of any illness / disease condition?

Any other previous medical details -

PREVIOUS/ EXISTING HEALTH INSURANCE DETAILS

Policy No./Application No	Insurer Name	Period of Insurance (from - to)	Sum Insured	Claims lodged during the preceding years

Do you have the same policy from any one or other insurer? Yes ☐ No ☐

If yes, Please share details below:

Policy No./ Application No.	Insurer Name	Period of Insurance (from—to)	Sum Insured	Claims lodged during the preceding years

ELECTRONIC INSURANCE ACCOUNT DETAILS SECTION

I want related information in -

Physical Format - Yes ☐ No ☐ e-Format (electronic) as & when applicable- Yes ☐ No ☐

Choose your Insurance Repository (For those selecting e-Format)

(a) NSDL Data Management Ltd. (b) CDSL Insurance Repository Ltd (c) Karvy Insurance Repository Ltd. (d) CAMS Repository Services Ltd

I have e Insurance Account & the No. is _____

My CKYC No. (Central Know Your Customer registry number) is (If available) _____

PREMIUM PAYMENT DETAILS

Name of Premium payer:	
Premium Payment Frequency:	Monthly ☐ Quarterly ☐ Half Yearly ☐
Premium Amount (in INR)	
Instrument Type:	Cash ☐ Cheque ☐ Debit Card ☐ Credit Card ☐ Others ☐ Please Specify:
Date (DD/MM/YYYY): _____ Bank Name: _____ IFSC Code: _____	Cheque no. _____ Bank Account Number: _____ Branch Name: _____

BANK ACCOUNT DETAILS FOR PROCESS OF REFUND

Cheque will be issued in the name of the Proposer only.

In case of cancellation of policy, if premium was paid through credit card the refund amount would be credited to Credit Card account directly or refund will be paid through cheque. Please provide the following bank details and a copy of Cancelled Cheque if you opt for direct credit of refund/ claim into your bank account: (Cancelled Cheque should be of the same bank account in which the refund needs to be credited directly.

Name of Accountholder		Cheque No	
Bank Name		Branch Name	
Cheque Date		Cheque Amount for INR	
Name as in Bank Account		Bank Account No	
IFSC Code		MICR Code	

Note: The Proposer agrees and undertakes to intimate in writing to Zurich Kotak General Insurance Company (India) Limited about any change in bank account details.

If ECS is selected, please submit the standing instruction form available at our branches.

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. I/We hereby declare on my behalf and on behalf of all persons proposed to be insured that the above statements are true and complete in all respects to the best of my knowledge and that I/We am/are authorized to propose on behalf of these other persons.

ii. I understand that the information provided by me will form the basis of insurance policy, is subject to the Board approved under writing policy of the Insurance company and that the policy will come into force only after full receipt to the premium chargeable.

iii. I/We further declare that I/We 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.

iv. I/We declare and further consent to the company. Seeking medical information from any hospital who at any time has attended on the life to be insured/proposer or from any past or present employer concerning anything which affects the physical and mental health of the life to be assured/proposer and seeking information from any insurance company to which an application or insurance on the life to be assured/proposer has been made for the purpose of underwriting the proposal and /or claim settlement.

v. I/We authorize the company to share information pertaining to my proposal including the medical records for the sole purpose of proposal underwriting and/ or claims settlement and with any Governmental and/or Regulatory Authority.

vi. I/We aware of premium loading, (if any declared above) for habit's & diseases as declared/ mention by me/ us above.

vii. I/ We hereby agree to keep record of KYC details of all the individual members covered under the group insurance, and ensure to provide the details of beneficiaries to the Company as and when required.

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*

ACKNOWLEDGEMENT:

Received from Ms. / Mrs./ Mr. _____

a sum of ₹ _____ through Cheque / DD _____ against your proposal for MediShield Policy.

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

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

Time H H M M 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 MediShield Policy 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. **Insurance is a subject matter of solicitation**

VERNACULAR DECLARATION

Applicable where the Proposer is illiterate or is suffering from a disability due to which writing is restricted or where the Proposer has signed in vernacular language.
(Note: The below must be witnessed by someone other than the Advisor/Employee of the Company).

I/We certify that the product applied for by me/us and the contents of the Proposal Form have been clearly explained to me/us and I/we have fully understood them. I/We further certify that the replies in the Proposal Form have been recorded as per the information provided by me/us. I, (Full name of the witness) _____ (Relation with the Proposer) _____ adult and inhabitant of (city) _____ and residing at _____ do hereby certify that I have read out and explained the contents of the Proposal Form and all other documents incidental to availing the insurance policy from Zurich Kotak General Insurance Company (India) Limited, to the Proposer and he/she/they have understood the same. I/we declare that whatever I/we have stated herein above is true and correct to the best of knowledge and belief.

Place* _____ Date* _____

Signature of the Witness

Signature/Thumb impression of the Proposer

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*

AGENT'S DECLARATION

I, _____ (Full Name) in my capacity as an Insurance Advisor/ Specified Person of the Corporate Agent/ Authorised 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 response(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 further more 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 premiums paid under the Policy may be forfeited to the company.

Place* _____ Date* _____

Signature of Agent License Number

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