ZURICH kotak
General Insurance

ZK - 25-26/v1

Surrogacy Care Proposal Form

SCPF

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

SECTION I

PROPOSER'S INFORMATION

Title Mr. / Miss / Mrs./ 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
Mobile*	Email*
Occupation*	☐ Business ☐ Salaried ☐ Professionals ☐ Student ☐ Housewife ☐ Retired ☐ Others
Profession*	☐ CA ☐ Paramilitary Services ☐ Govt. Teacher ☐ Govt. Employee ☐ Medical Doctor ☐ Others
Annual Income	Up to 2.5 lacs ☐ 2.5 - 6 lacs ☐ 6 - 10 lacs ☐ 10 - 15 lacs ☐ 15 - 20 lacs ☐
	20 - 25 lacs ☐ >25 lacs ☐
PAN*:	/Form 60 (only in case the customer does not have PAN No.)
GSTIN	
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 License ☐ Voter ID ☐ Others (Please specify): ☐

Zurich / Kotak Group Employees ☐ Yes ☐ No If 'Yes', Employee ID

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

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

SECTION II

PROPOSAL DETAILS

Select Any one Section below		
Type Of Cover	Section 1 - Oocyte Donor ☐	Section 2 - Surrogate Mother ☐
Proposer Type	Intending Couple ☐	Intending Couple ☐
	Intending Woman ☐	Intending Woman ☐
Procedure Details	Proposed Oocyte Retrieval Date - D D M M Y Y Y Y	Proposed Surrogacy Procedure Date - D D M M Y Y Y Y
History Of	Oocyte Retrieval ☐ Yes ☐ No	Surrogacy ☐ Yes ☐ No
Policy should be availed before commencement of the Surrogacy Procedure or oocyte retrieval		
Sum Insured -- ☐ 5 Lacs ☐ 10 Lacs		
Proposed Start Date*		

SECTION III

INSURED INFORMATION

Insured Details

Name in Full*	Nationality*	Date of Birth DD/MM/YYYY*	Gender*	Height (in cm)*	Weight (in kg) *	Occupation*	ABHA Number	Marital Status*

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.

Section A: Medical and Hospitalisation Information	
Details of hospitalization for the illness / ailment / Medicine / Test / Surgery	
Are you currently in good mental and physical health – Yes ☐ / No ☐	
Are you currently suffering or previously suffered from any illness and on continuous medication for same- Yes ☐ / No ☐ (If Yes, please provide documents for same)	
Name the medication and duration since on treatment	
Is the Person proposed for Insurance Surrogate Mother and also Oocyte Donor	
Number of attempts of surrogacy procedures/ oocyte donation if any	
Diabetes Mellitus If Yes provide duration, type I or II and name of medication	
High BP, Cholesterol If Yes since when and medication being taken	
Have you undergone any medical test or health check–up in the past 6 month if yes then please mention if any abnormal result detected	
Any hospitalization in the past – Yes / No (If Yes, Please provide documents for same)	
Period of hospitalization	

Have You or any of the person proposed to be insured ever suffered from / are suffering from any of the following: Please tick 'YES" for insured wherever applicable	
Infections / Allergies	
HIV / AIDs	
Cancer / Tumor / Cyst	
Nutritional / Endocrinal disorders / Diabetes	
Mental psychiatric Disorders	
Nervous system Disorders	
Disorders of the Eyes / Ears / Nose / throat/	
Disorders of the circulatory system / Heart Disease/ hypertension	
Respiratory Infections and Diseases, Asthma	
Bones and Joints, Spondylitis / arthritis etc.	
Diseases of Stomach, Intestines, liver, appendix	
Kidney and urinary system	
Gynaecological Disorders	
Birth Defects	
Accidents / burns	
If any accident in past please give details:	
Year of Accident	
Accident resulting in to deformity or disability hampering mobility	
Section B: Lifestyle Information	
Have You or any of the person proposed has any of the following Habit?	
Smoking / Tobacco consumption – Yes / No	
If Yes, Duration and Quantity per day	
Alcohol consumption- Yes / No	
If Yes, Duration and Quantity	
Section C: Existing Health Insurance Details	
Type of Policy	
Period of Insurance	
Insurance Company	
Base Sum Insured (Rs.)	
Section D: Details of claims	
Ailment for which claim was made	
Claim amount paid/rejected	
Year of claim	
Others Have You or any person proposed to be insured under the Policy has ever been refused insurance cover by an insurance company or been accepted on special terms? (YES / No)	
If yes, please give full detail Any Pre-existing diseases	
Number of Child(ren) if any (Applicable if Insured is Married) Note: Please provide an additional sheet if space is not sufficient to complete details.	

SECTION IV

***PAYMENT DETAILS**

☐ Cheque ☐ Demand Draft ☐ Credit Card ☐ Online Payment

Cheque / D.D # Amount Drawn On

Date Bank

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

IFSC/MICR Code

For Credit/Debit Card

Transaction Reference No. Transaction Date

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

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.**

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.

☐ Cancelled Cheque submitted of Other Bank

Particulars of Bank Account:

Account Number ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ IFSC/MICR Code ☐☐☐☐☐☐☐☐☐

Bank Name ☐☐

Account Holder Name ☐☐

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 and Stamp of Proposer

ELECTRONIC INSURANCE ACCOUNT DETAILS OF PROPOSER (E-mail id is mandatory)

Do you have an EIA Account	☐ Yes ☐ No
If Yes, please quote EIA Number	
Please mention name of Insurance Repository:	
If No, do you want Us to create an EIA account for you	Yes ☐ No (If Yes, please fill up Insurance Repository Application form)
Email id (to be registered with Insurance Repository)	
Your address details as mentioned in the EIA account shall override the address provided in this application for Insurance	

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/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.

ACKNOWLEDGEMENT

Received from Ms. /Mrs. / Mr. ☐

a sum of Rs. ☐ Through Cheque/DD ☐ against your proposal for Surrogacy Care policy.

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

Date ☐

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 Surrogacy Care 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.

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