

**PROPOSAL FORM -  
A PLUS HEALTH INSURANCE**



Application No:

Agent Code:

**Guidelines For Completion Of The Form (to Be Filled By Proposer): -**

1.This is an application for insurance and issuance of this does not amount to acceptance of proposal by us. Commencement of risk under this proposal is subject to acceptance of the risk by us and receipt of premium. 2.The information declared by you in this form is the basis for issuance of the policy. Please answer all questions carefully and in BLOCK letter. Any incomplete, incorrect, or partially correct answers may lead to rejection of the proposal.

**For Office Use Only**

Intermediary Name:		Intermediary Contact No.:		Intermediary Reference Code:	
Intermediary Email:		Intermediary Sales Person's Name:			
Intermediary Sales Person's Contact:		Intermediary Sales Person's Code:		Source Code:	
POS UID Aadhar No./PAN:		Policy Issuing Office Code			
Policy Issuing Office Address:					

**1. PROPOSERS DETAILS**

<b>Name of the Proposer</b>					
<b>Gender</b>	Male <input type="checkbox"/>	Female <input type="checkbox"/>	Third Gender <input type="checkbox"/>	<b>Date of Birth</b>	DD/MM/YYYY
<b>Marital Status</b>	Married <input type="checkbox"/>	Single <input type="checkbox"/>	Others <input type="checkbox"/>		
<b>E Mail ID</b>				<b>Mobile No.</b>	
<b>ID Type</b>	Aadhar Card* <input type="checkbox"/>	Driving License <input type="checkbox"/>	Passport <input type="checkbox"/>	Pan Card <input type="checkbox"/>	<b>ID Number</b>
<b>CKYC No.</b>				<b>Pan Card No.</b>	
<b>Occupation</b>	Salaried <input type="checkbox"/>	Self Employed <input type="checkbox"/>	Other <input type="checkbox"/>		
If salaried, specify designation			If self employed, specify business/occupation		
<b>Annual Income</b>	1 to 10 L <input type="checkbox"/>	11 to 20 <input type="checkbox"/>	21 to 50 Lakh <input type="checkbox"/>	Above 50 Lakh <input type="checkbox"/>	
<b>Address</b>					
<b>Landmark</b>					
<b>City</b>		Pin code		State	
<b>Nationality</b>					

\* Mandatory

**2. POLICY DETAILS**

<b>Cover Type</b>	Individual <input type="checkbox"/>	Family Floater <input type="checkbox"/>			
<b>If Family Floater*, number of persons to be covered</b>	Adults :	Children :			
<b>Policy Type</b>	New <input type="checkbox"/>	Renewal <input type="checkbox"/>	Migration <input type="checkbox"/>	Portability <input type="checkbox"/>	
<b>Policy Period</b>	1 year <input type="checkbox"/>	2 year <input type="checkbox"/>	3 year <input type="checkbox"/>		
<b>Policy Tenure From</b>	DD/MM/YYYY	<b>Policy Tenure To</b>	DD/MM/YYYY		
<b>Premium Payment Frequency :</b>	Yearly <input type="checkbox"/>	Half yearly <input type="checkbox"/>	Quartely <input type="checkbox"/>	Monthly <input type="checkbox"/>	Single <input type="checkbox"/>
<b>No Claim Bonus can be opted through :</b>	Enhancement in Sum Insured <input type="checkbox"/>		Discount in Premium <input type="checkbox"/>		

**3. PLAN DETAILS**

<input type="checkbox"/> Silver	<input type="checkbox"/> Gold	<input type="checkbox"/> Diamond								
3 L <input type="checkbox"/>	5 L <input type="checkbox"/>	7.5 L <input type="checkbox"/>	10 L <input type="checkbox"/>	12.5 L <input type="checkbox"/>	15 L <input type="checkbox"/>	20 L <input type="checkbox"/>	25L <input type="checkbox"/>	50L <input type="checkbox"/>	75L <input type="checkbox"/>	100L <input type="checkbox"/>

**4. DETAILS OF THE PERSON TO BE COVERED**

Sl. No	Insured Name (First, middle, Last)	Date of birth (DD/MM/YYYY)	Age	Gender (M/F/T)	Relationship with proposer	Height (cm)	Weight (kg)	Occupation

**ABHA ID (Ayushman Bharat Health Account)**

<b>Insured 1</b>	<b>Insured 2</b>	<b>Insured 3</b>	<b>Insured 4</b>	<b>Insured 5</b>	<b>Insured 6</b>

**5. NOMINEE DETAILS**

The nominee must be an immediate relative of the proposer. The nominee for all other Insured Persons proposed to be insured shall be the Proposer himself/herself.

Sr No	Name of Insured	Name of Nominee	Date of Birth	Age	Relationship	Gender (M/F/TG)	Mobile No / Email Id	Address of the Nominee	Bank A/C Details of Nominee

\*If the Nominee is Minor, Name and relationship with minor.

Name of the Appointee	Relationship	Date of Birth	Age	Gender(M/F/TG)	Address of the Appointee

**6. BASE COVERS**

1.In-patient Treatment	6.Domiciliary Treatment	11.Global Cover( Applicable only for Diamond Plan)
2.Pre-Hospitalization	7.Second Opinion	12.Psychiatric Illness
3.Post-Hospitalization	8.Ambulance Cover	13.Organ Donor
4.Day Care Procedures	9.Auto Restore Benefit	14.Assistance Services
5.AYUSH Treatment	10.OPD Expenses ( Only for Diamond Plan)	15.Wellness Services

**7. RENEWAL BENEFITS**

	Silver Plan	Gold Plan	Diamond Plan
<b>Cumulative Bonus</b>	20% of Base maximum upto 100%	50% of Base maximum upto 100%	50% of Base maximum upto 200%
<b>Health Check Up</b>	Preventive Health Check up every claim free Year upto Rs.1000	Preventive Health Check up every claim free Year upto Rs.2500	Preventive Health Check up every claim free Year upto Rs.5000

**8. ADD ON COVERS ( Please Tick (v) Add on you wish to have in your Policy)**

Covers	Insured 1	Insured 2	Insured 3	Insured 4	Insured 5	Insured 6
1. Pre-Existing Disease Waiting Period Waiver	<input type="checkbox"/>					
2. Maternity Cover (36 months waiting period)	<input type="checkbox"/>					
3. Diabetes Day 1 cover (ONLY FOR Diamond plan)	<input type="checkbox"/>					
4. Hypertension Day 1 Cover (ONLY FOR Diamond plan)	<input type="checkbox"/>					
5. Non-Medical Items	<input type="checkbox"/>					

**9. MEDICAL AND LIFESTYLE INFORMATION**

Please answer the below mentioned questions accurately to the best of your knowledge in respect of each person proposed to be insured. If the answer to any of these questions is YES, please provide the complete details in the table for additional medical information.

**Important:** You must answer these questions truthfully.

Sl. No	Details	Insured 1	Insured 2	Insured 3	Insured 4	Insured 5	Insured 6
1.	Are you or the proposed Insured Member suffering from any illness or disease at present or in the recent past? If yes, please give details	Yes <input type="checkbox"/> No <input type="checkbox"/>					
2.	Are you or the proposed insured member taking any type of treatment or medicine? If Yes, please give details	Yes <input type="checkbox"/> No <input type="checkbox"/>					
3.	Have you or the proposed insured member visited a doctor or medical professional for any health problem in the last 4 years? If yes, please give details	Yes <input type="checkbox"/> No <input type="checkbox"/>					
4.	Have you or the proposed insured member been hospitalized for operation/medical treatment in the last 4 years? If yes, please give details	Yes <input type="checkbox"/> No <input type="checkbox"/>					
5.	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. If yes, please give details	Yes <input type="checkbox"/> No <input type="checkbox"/>					

For questions marked Yes (Y) in above Section, please specify following information:

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.

Does any person proposed to be insured consume any of the following

Substance	Insured 1	Insured 2	Insured 3	Insured 4	Insured 5	Insured 6
Alcohol	Yes <input type="checkbox"/> No <input type="checkbox"/>					
	Quantity**					
	No. of Years					
Smoking	Yes <input type="checkbox"/> No <input type="checkbox"/>					
	Quantity(No./Day)					
	No. of Years					
Any other substance like Tobacco/Guthka/Pan/ Pan Masala, etc	Yes <input type="checkbox"/> No <input type="checkbox"/>					
	Quantity(Pouch/Day)					
	No. of Years					
Narcotics	Yes <input type="checkbox"/> No <input type="checkbox"/>					
	Quantity(Pouch/Day)					
	No. of Years					

\*\*Beer – No. 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\_\_\_\_\_

**10. ADDITIONAL MEDICAL INFORMATION**

If you have answered YES to any of the questions in section 4, please give full details here. If you need more space please use extra sheets.

If you are unsure whether any details are relevant, please include them

Substance	Insured 1	Insured 2	Insured 3	Insured 4	Insured 5	Insured 6
Name of illness/injury suffering from or suffered in the past						
Date of first diagnosis (Month & Year)						
Treatment/medication received/receiving						
Treatment outcome (fully cured/partially cured/ ongoing, etc)						

**Note:**

Company may apply an exclusion/risk loading on the premium payable (based upon the declarations made in the proposal form and the health status of the members proposed to be insured). These loadings would be applied from the policy period start date including all subsequent renewals with the company. Any exclusion/loadings, if applicable, shall be suitably intimated to the proposer based on the assessment of the proposal form and medical tests. Proposer shall be required to pay the additional premium within stipulated time of such intimation. Company shall not be at any risk during this period. In the event of the decline of proposal due to non-receipt of this additional premium within the stipulated time or due to any reason, Company shall cancel your proposal and refund the premium amount after deducting charges as per policy terms and conditions.

**11. PREGNANCY INFORMATION**

1	Is anyone currently pregnant? If yes, please mention expected date of delivery _____ (DD/MM/YYYY)	<input type="checkbox"/> Yes <input type="checkbox"/> No
2	Any complaint of diabetes, hypertension or any complication during current or earlier pregnancy? If you answered "Yes" to any of the questions in Medical History above, then please provide details in the table below	<input type="checkbox"/> Yes <input type="checkbox"/> No

**12. GENERAL INFORMATION****I. Family Physician details:**

Family Physicians name \_\_\_\_\_ Contact Number \_\_\_\_\_

**II. Existing Insurance Details**Is the proposer or any of the persons proposed to be insured already insured under or proposed for a health insurance policy with Universal sompo General Insurance Co. Limited or any other insurance company Yes  No 

If YES, please indicate below the Policy/Application number(s). (Please mention application number in case of pending proposal) Since when have you been continuously insured DD MM YYYY

Sr No	Policy No	Name of insured person	Insurer	Period of Insurance		SI & Cumulative bonus /Rs	Claims details if any
				From (DD/MM/YYYY)	To (DD/MM/YYYY)		
1							
2							
3							
4							
5							
6							

If you want to avail the portability benefit from your existing insurance policy, please also submit to us (as an annexure to this proposal form) all the policy documents relating to the existing policy in addition to the information given above.

**For Active policies, please attach policy copies.**

Insured wise information required with all the above information in Previous/Current Insurance Details.

**III. 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.

**IV. 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 at \_\_\_\_\_ (Please provide us your e-mail id)

 I hereby consent to and authorize Universal Sompo 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.

 Auto Debit Authorization For Current and Future Payments

I hereby Authorize Bank to debit my account number \_\_\_\_\_ with the bank of Rs. \_\_\_\_\_ towards premium for availing the said Universal Sompo Health Insurance Cover.

 I hereby request and authorize Bank to debit my Account number \_\_\_\_\_ on the yearly due date with the applicable Renewal Premium.

Date : \_\_\_\_\_

Signature of the Proposer: \_\_\_\_\_

Place : \_\_\_\_\_

Name of Proposer : \_\_\_\_\_

**13. PAYMENT & BANK ACCOUNT DETAILS**Payment Option :  Cheque  Demand Draft  Fund Transfer  Pay Order  Debit Card  Credit Card  Cash

Premium Amount Rs. \_\_\_\_\_ Amount (In Words): \_\_\_\_\_

For Cheque/DD/PO (Payable in favour of Universal Sompo General Insurance Company Ltd)

Name of the Account Holder:	Instrument Amount (Rs) :
Instrument No.:	Bank A/C No.:
Instrument Date:	Bank Name and Branch:
IFSC Code :	UPI Id :
Type of Account : Saving <input type="checkbox"/> Current <input type="checkbox"/> Other ( Please Specify ) <input type="checkbox"/>	
Fund Transfer/Wallet : _____ Name of Bank/Wallet	Transaction No.
PAN Number :	TAN Number :

Please make a A/C Payee Cheque/DD/Pay Order in favour of 'Universal Sompo General Insurance Company Limited' only

BANK ACCOUNT DETAILS REQUIRED FOR REFUND OR CLAIM PURPOSE	
Name of Account holder	
Bank Name & Branch:	
Bank Account Number	
IFSC Code	

**14. E- ACCOUNT OPENING**

Do you have eIA account? If Yes, Account details	
I would like to apply for eIA with :	Karvy <input type="checkbox"/> CAMS <input type="checkbox"/> NSDL <input type="checkbox"/> CSDL <input type="checkbox"/>

**15. MEDICAL EXAMINATION**

We may ask You or any of the beneficiaries to undergo below mentioned medical tests for purpose of consideration of Your proposal in the following events

- You or any of the beneficiaries is/are above 45 years of age as on Your last birthday.
- On basis of above medical conditions/ health status declaration.

## 16. DECLARATION

- 1./I/We 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/We am/are 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 insurance company and that the policy will come into force only after full receipt of the premium chargeable.
- 3.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.
- 4.I/We declare and consent to the company seeking medical information from any doctor or from a hospital who at anytime has attended on the life to be insured/proposer or from any past or present employer concerning anything which affects the physical or mental health of the life to be assured/proposer and seeking information from any insurance company to which an application for insurance on the life to be assured/proposer has been made for the purpose of underwriting the proposal and/or claim settlement.
- 5.I/We authorize the Company to share / verify the information provided by me/us pertaining to my proposal with rating agencies, third parties or services providers for the purpose of underwriting the proposal, issuance, servicing and claims settlement of the policy, thereafter.

I hereby consent to and authorize Universal Somp General Insurance Company Limited ("Company") and its representatives to collect, use, share and disclose information provided by me, as per the Privacy policy of the Company. Company or its representatives are also hereby authorised to contact me (including overriding my registry on NCPD/NDNC and/or under any extant TRAI regulations) and / or notify about the services being rendered by the Company.

### Go Green

We would like to protect our environment and would like to save paper by sending all Policy and service related communication to the email id as mentioned in this form. By choosing this option, you wish to avail Physical Policy Copy.

Date : \_\_\_\_\_  
Place : \_\_\_\_\_

Signature of the Proposer: \_\_\_\_\_  
Name of Proposer : \_\_\_\_\_

## AML guidelines

1. I / we hereby confirm that all premiums paid / payable in future will be from bonafide sources and not paid out of proceeds of crime and that such premiums are not disproportionate to my/our income. I / we understand that the Company has the right to call for documents to establish sources of funds and to cancel the insurance policy in case I / we are found guilty by any competent court of law under any of the statutes, directly or indirectly governing the prevention of money laundering law in India.

2. I / we are not Politically Exposed Persons \*\* nor are their close relatives /family members/associates. I / we shall keep the company informed if we subsequently become a Politically Exposed Person.

\*\*"Politically Exposed Persons" shall have the meaning assigned to it under Prevention of Money-Laundering (Maintenance of Records) Amendment Rules, 2023 as amended from time to time.

## Disability Declaration

I/We hereby declare that a duly authorized representative appointed by me has explained details with respect to the proposal form, policy documents, terms and conditions and the EIA Name of Representative:

Signature of Representative:

## CKYC Declarations

I hereby give consent to Universal Somp General Insurance Co Ltd to verify and obtain my information through Central KYC Registry or UIDAI or through any other modes for the purpose of undertaking KYC.

I hereby declare that the details furnished above are true and correct to the best of my knowledge/belief and I undertake to inform you in writing with the copy of updated documents in case of any change in my KYC details.

## 17. VERNACULAR DECLARATION

I hereby declare that I have fully explained the contents of the Proposal Form and all other documents incidental to availing the health insurance from Universal Somp General Insurance Company Limited to the Proposer in the language understood by him/her and that the Proposer has affixed the thumb impression above after fully understanding the contents thereof. The same have been fully understood by him/her and the replies have been recorded as per the information provided by the Proposer and the replies have been read out to fully understood and confirmed by the Proposer.

Date : \_\_\_\_\_  
Place : \_\_\_\_\_

Signature of the Proposer: \_\_\_\_\_  
Name of Proposer : \_\_\_\_\_

## 18. AGENT 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 further confirm that I have explained the product features, terms and conditions to the prospect and the product opted is suitable to the need of the customer.

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.

License No. (Advisor/Corporate

Agent/Broker/Relationship Officer): \_\_\_\_\_

Date: \_\_\_\_\_ Place: \_\_\_\_\_ Signature of Agent \_\_\_\_\_

## 19. INSURANCE ACT 1938, SECTION 41 - 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 or 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 prospectus 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.

## 20. CHECK LIST

Please check the following documents are attached along with the proposal form

- |  |  |
|--|--|
| <input type="checkbox"/> ID Proof : Passport/ PAN Card/ Voter ID/ Driving License/ Letter from a recognized public authority                                   | <input type="checkbox"/> Renewal Notice with claim details                     |
| <input type="checkbox"/> Proof of residence: Telephone Bill/ Bank Account Statement/ Letter from any recognized public authority/Electricity Bill/ Ration Card | <input type="checkbox"/> Photocopies of all previous policies and endorsements |
| <input type="checkbox"/> Age Proof: Proof of Age   |  |
| <input type="checkbox"/> Certification of previous insurer for previous claim details  |  |

## Universal Somp General Insurance Co. Ltd.

Unit No 601/602, A Wing, 6th Floor, Reliable Tech Park, Cloud City Campus, Gut No 31, Mouje Elthan, Thane Belapur Road, Airoli, Navi Mumbai - 400708  
Toll Free No : 1800 200 4030 / 1800 22 4030, for Senior Citizen : 1800 267 4030

Registered and Corporate Office : 8th & 9th Floor (South Side), Commerz International Business Park, Oberoi Garden City,  
Off Western Express Highway, Goregaon East, Mumbai 400063. Email : contactus@universalsomp.com

Insurance is the subject matter of solicitation. For more details on risk factors, terms and conditions please read Policy Documents carefully before concluding a sale. IRDAI or its officials do not involve in activities like sale of any kind of insurance or financial products nor invest premiums. IRDAI does not announce any bonus. Those receiving such phone calls are requested to lodge a police complaint along with details of phone call and number.

CIN: U66010MH2007PLC166770, URN No: USGHP135

A Plus Health Insurance

UIN : UNIHLIP23125V012223

IRDAI Reg No:134

## 21. ACKNOWLEDGEMENT CUSTOMER COPY

Please retain this counterfoil for your records (on behalf of Universal Somp General Insurance Company Limited)

Date : DD/MM/YYYY

We acknowledge with thanks the receipt of your proposal and amount by Cheque/NEFT/DD/Cash/Others No. \_\_\_\_\_

of amount of Rs. \_\_\_\_\_ dated \_\_\_\_\_ drawn on \_\_\_\_\_

from Mr./Mrs./Ms. \_\_\_\_\_

Date : \_\_\_\_\_ Signature of the receiver and office seal: \_\_\_\_\_

Neither the submission to us of a completed proposal for insurance nor any payment for any policy sought obliges us to agree to issue a policy, which decision is and always shall be in our sole and absolute discretion. 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 if premium is not received by us in full and in time, or is not realized. If we do not accept the proposal, we will inform you and refund any payment received from you without interest within next 30 days.

Insured person may contact the company through Universal Somp General Insurance Co. Ltd.

Unit no: 601 & 602, A and B Wing, 6<sup>th</sup> Floor, Reliable Tech Park, Cloud-City Campus, Gut No:31, Mouje Elthan, Thane-Belapur Road, Airoli, Navi-Mumbai-400708  
www.universalsomp.com, Toll free No : 1800 200 4030/1800 22 4030 for senior citizen : 1800 267 4030, email : contactus@universalsomp.com