## PROPOSAL FORM - LOAN SECURE INSURANCE POLICY



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@universalsompo.com

## 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 <a href="BLOCK">BLOCK</a> letter. Any incomplete, incorrect, or partially correct answers may lead to rejection of the proposal.

For Office Use Only

Intermediary Name:	$\longrightarrow$				Intermediary	/ Con	tact No.	:	_			Interme	diary Reference Co	ode:	
Intermediary Email:					Intermediary	/ Sale	s Person	ı's Nan	ne:						
Intermediary Sales Person's Contact:				les Person's Code:					Source Code:						
POS UID Aadhar No./PAN:					Policy Issuing	g Offi	ce Code								
Policy Issuing Office Address															
F 1: D :				Chequ	e/							Cheque/			
Forwarding Date				Transac	ction Date							Transaction II	O Amt.		
Bank Name				Chequ								Branch Name			
				Transac	ction ID No										
Hypothecation															
Name of SP							Na	me of	BA	١					
					Applicant	- 1						Applica	ınt – II ( if ap	plicable)	
Name Mr/ Mrs/Ms	IN CAPITAI	L) :													
Applicant Status :				1	1ain Borrow	ver						Со Во	orrower		
Relationship between	n both a	applica	ants												
Address for corresp	ondence	e :				T			T						
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Contact Details : Pho			Phone (	hone (O) :				Pho				one (O) :			
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Occupation :				ned ier Speci	fy	ш	Sell L	.mpi	Jye	eu .		Other Speci			
Confirmation for Issua	nce of e-Ir	nsuran			<i>-</i>									I would like to	
open E-Insurance accour							ınce Re	po <u>sito</u>	ry.						
PAN No./Form 60					Aadh	ar C	ard No	).							
Nominee informatio	ı (please	e prov	ide deta	ails as pei	r order men	tion	ned in	prop	ose	ed in	sure	d information	1)	•	
The nominee must be														d shall be the	
Proposer himself/herse		naco i c	JIGGITO OI	the prope	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		0 101 0		· .	. ioui	00.0		a to be moune	a shan be the	
Sr					Date of					Go	ndar	Mobile No /	Address of	Bank A/C Details	
No Name of Insured Name		me of Nominee		Birth	4ge	ge Relationship		ip	Gender (M/F/TG)		1 ,	the Nomine			
110					Birtir				$\dashv$	(1717	1/10	) Liliali Id	the Northine	e of Northinee	
*If the Nominee is Mine	or, Name	and re	elationshi	ip with mi	nor.										
Name of the Appoi	ntee		Relations	ship	Date of Bi	irth	Age		ien	der(l	M/F/T	G)	Address of the	e Appointee	
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Amount of Loan Sa	nctioned	1: 1	Rs.						D	ate	of Lo	an Sanctione	ed: DDM	MYYYY	
											Oan l	Disbursal Dat	e · DDM	MYYYY	
Loan Account Num	ber :									_		Tenure of Loa		ears	
D i: 6 1							1								
Policy Sum Insured	<u>:                                    </u>		Rs.									loan amount -			
Type of Policy :			□Fixe	ed Sum II	nsured		□ Red	ucing	ςSι	ım l	nsure	ed Ter	nure of Policy	Years Years	
Period of Insurance	:		From	DDM	MYYY	Υ				To	<b>D</b>	DMMY	YYY		
Premium Amount :			Rs.												
Applicant - I - I de		ovice		es (if any)	١٠										
Details of previous						al II	lness								
a. Insurance Compar	y:		eo po.				b	Poli	y N	No:_					
a. Insurance Compar c. Sum Insured:					d. Policy	Peri	od Fo	rm: _					To:		
Claims (if any):															
Applicant - 11-1 c	eclare P	re-ev	isting III,	ness (if ar	υΛ).										
				,											
Details of previou a. Insurance Compa	/existing	g insu	rance po	olich(s) c	overing Crit	ıcal	iiines	b. Pol	icv	No.					
a. Insurance Compa c. Sum Insured:	.,				d. Polic	v Pe	riod F	orm.	-7				 То:		
Claims (if any):					=	•									
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			Cover									Sum Insur	eu KS.		
I. (a) Major Medica				•							_				
(b) Insurance Pla		en (No	o. of Majo	or Illness	& Procedures	s.)	Si	ver P	lan	(9)	Gold	Plan(12) Plan	inum Plan(15	Diamond Plan(I	
II. Personal Accider	it											(Not to exce	eed above limit)	A d d	
III. Loss of Employn	ent of Ir	nsure	d Person	(Limited t	o total of 3 EM	l*)				T		(Mention cu	rrent EMI)	Address of occupan Risk Location:-	
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IV. Fire and Allied P	erils —				loan amount)	,	1	+	+	+	+			1	
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<sup>\*\*</sup>Terrorism Yes No

\*\*Please Note:- Additional Premium required for Earthquake & terrorism

<sup>\*</sup> Benefit III. – Loss of employment cover of insured person is available for Salaried Employees only.

Premium Payment and Bank 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 Com	
Name of the Account Holder:	Instrument Amount (Rs):
Instrument No.:	Bank A/C No.:
Instrument Date:	Bank Name and Branch:
IFSC Code :	UPI ld:
Type of Account : Saving Current Other ( Please Specify )	
Fund Transfer/Wallet : Name of Bank/Wallet	Transaction No.
PAN Number :	TAN Number :
Sources of funds: Salary/Business/Other pleasespecify: Please make a crossed Cheque /DD/Pay order in favor of "Universal Sompo Genera *PAN Card copy in Mandatory for premium of premium of 50,000 and above menti- payment to be collected only from Proposer's card/Bank Account.  BANK ACCOUNT DETAILS REQUIRED FOR REFUND OR CLAIM PU	oned in Cash/DD or 1,00,000 and above by Cheque/Credit/Debit Card
Name of Account holder	
Bank Name & Branch:	
Bank Account Number	
IFSC Code	
<b>Debit Authorization for Current &amp; Future Renewal Premiums</b>	
I hereby authorize bank to debit my account number towards first premium for availing the said Universal Sompo Health Insurance Cove I hereby request and authorize the bank to debit my account number applicable renewal premium.	with the bank for Rs r on the yearly due dates with the
Declaration - Applicant I	Declaration - Applicant II
I confirm that I am in good health and have not currently or in the past 5 years been suffering or receiving medication in respect of high blood pressure, diabetes or any other serious illness. I also confirm that I have never been postponed or declined for Major Medical Illness coverage and that I have never been diagnosed or received medical care for any of the following conditions:  1. Stroke (including Transient Ischemic Attack) 2. Hepatitis B or C 3. Alcoholism 4. Drug Abuse 5. Cancer (other than skin cancer) 6. Skin Cancer (2 or more occurrences) 7. Melanoma 8. Abnormal Kidney Functions 9. Alzheimer's or Senile Dementia 10. Recurrent Human Papilloma virus (HPV) or Sexually Transmitted Disease (within the past 5 years) 11. Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), Human Immunodeficiency. Virus infection (symptomatic or asymptomatic) or any AIDS related condition 12. Any Disease or Disorder of the Nervous System 13. Heart Attack 1 authorise the Company and their agents to exchange, share or part with all the information provided to other Agencies/ Statutory Bodies as may be required and I will not hold the Company and their agents liable for use of this information.  1 agree that the Policy shall become voidable at the option of the Company, in the event of any untrue or incorrect statement, misrepresentation, non-description or non-disclosure	I confirm that I am in good health and have not currently or in the past 5 years been suffering or receiving medication in respect of high blood pressure, diabetes or any other serious illness. I also confirm that I have never been postponed or declined for Major Medical Illness coverage and that I have never been diagnosed or received medical care for any of the following conditions:  1. Stroke (including Transient Ischemic Attack) 2. Hepatitis B or C 3. Alcoholism 4. Drug Abuse 5. Cancer (other than skin cancer) 6. Skin Cancer (2 or more occurrences) 7. Melanoma 8. Abnormal Kidney Functions 9. Alzheimer's or Senile Dementia 10. Recurrent Human Papilloma virus (HPV) or Sexually Transmitted Disease (within the past 5 years) 11. Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), Human Immunodeficiency. Virus infection (symptomatic or asymptomatic) or any AIDS related condition 12. Any Disease or Disorder of the Nervous System 13. Heart Attack 1 authorise the Company and their agents to exchange, share or part with all the information provided to other Agencies/ Statutory Bodies as may be required and I will not hold the Company and their agents liable for use of this information.  1 agree that the Policy shall become voidable at the option of the Company, in the event of any untrue or incorrect statement, misrepresentation, non-description or non-disclosure
in any material particular in the proposal form/personal statement, declaration and connected documents, or any material information has been withheld by me or anyone acting on my behalf to obtain any benefit under this Policy.  I, the undersigned hereby declare and warrant that the above statements are true, accurate and complete. I desire to effect an insurance as described herein with the Company and I agree that this proposal and declarations hereto shall be the basis of contract between me and the Company and I agree to accept a Policy subject to the conditions prescribed by the Company.  I agree that the issuance of Policy/Cover Note shall be subject to realisation of premium cheque.  I hereby agree and confirm that if the amount collected is less than the premium quoted or revised as per changes in sum proposed for insurance or scope of cover desired by me, the proposal shall be considered for acceptance for a reduced sum appropriate to the premium collected and the Policy shall be finalised accordingly.	in any material particular in the proposal form/personal statement, declaration and connected documents, or any material information has been withheld by me or anyone acting on my behalf to obtain any benefit under this Policy.  I, the undersigned hereby declare and warrant that the above statements are true, accurate and complete. I desire to effect an insurance as described herein with the Company and I agree that this proposal and declarations hereto shall be the basis of contract between me and the Company and I agree to accept a Policy subject to the conditions prescribed by the Company.  I agree that the issuance of Policy/Cover Note shall be subject to realisation of premium cheque.  I hereby agree and confirm that if the amount collected is less than the premium quoted or revised as per changes in sum proposed for insurance or scope of cover desired by me, the proposal shall be considered for acceptance for a reduced sum appropriate to the premium collected and the Policy shall be finalised accordingly.
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Applicant - I	Applicant – II
Place:Signature:	Place:Signature:
B. DDMMYYYY	D-t D D M M Y Y Y Y N

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.  2.1 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 including seeking and/or sharing of my medical data through ABHA.  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 Sompo 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 NCPR/NDNC and/or under any extant T
Date :         Signature of the Proposer:           Place :         Name of Proposer :
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AML guidelines   I. 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 Sompo 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

## 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.

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.

## Universal Sompo General Insurance Co. Ltd.

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

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 compliant along with details of phone call and number.

CIN: U66010MH2007PLC166770, URN: USGIHP116

updated documents in case of any change in my KYC details.

**Declaration**