



Universal Sampo General Insurance Co. Ltd.

(A joint venture of Allahabad Bank, Indian Overseas Bank, Karnataka Bank Ltd., Dabur Investment Corp. and Sampo Japan Insurance Inc.)

Regd. Office : Unit No 401, 4th Floor, Sangam Complex, 127, Andheri Kurla Road, Andheri (E), Mumbai - 400059, Maharashtra.

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HOSPITAL CASH INSURANCE PROPOSAL FORM

Instruction to the Applicant

This proposal should be answered after detailed enquiry of all persons to be covered

1. You must answer all the questions in this form. If a question is not applicable, state "N/A". If more space is required to answer a question, please attach additional sheets

2. If You have any questions concerning this proposal, please contact your insurance advisor or the Company to discuss

1. Name: _____

2. Address: _____

City: _____ Pin Code: _____

State : _____ Date of Birth : _____

3. Phone Number: _____

4. Email Address: _____

5. Identification Proof Number: Please tick

Driving License Number Aadhar Card Number Pan Card Number Passport Number

Any other (please specify): _____

6. Occupation : _____

7. Annual Salary : _____

8. Do you wish to cover your family members in the Policy? Yes No

If yes, please provide details in the format as per below.

Sr. No.	Name of the Family Members	Relationship with you	Gender	DOB	Name of PEDs, if any	Name of Nominee	Relationship with Nominee

9. Please provide details of pre-existing disease/ illness/ condition suffered by you or your family member (if any): _____

10. Please provide details of Hereditary Diseases (if any) /Family Medical History : _____

Sr. No.	Questions	Insured 1	Insured 2	Insured 3	Insured 4	Insured 5	Insured 6
1.	Have any infirmity/sickness or any medical complaint	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
2.	Have suffered from any one of the following						
a.	Any nervous, mental or psychiatric disease or sickness	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
b.	Slipped disc or other spinal disorder or paralysis (including but not limited to fainting episode blackout, fit) of any kind	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
c.	High blood pressure, heart disease, including ischemic heart disease, other circulatory disorders	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
d.	Fistula, piles, hernia, varicose, veins	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
e.	Any disease of the bones on joint including rheumatic disease	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
f.	Disease of uterus, ovaries or breast or any specific gynecological disorders	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
g.	Any respiratory or allergic disease	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
h.	Any disorder of the stomach, ulcer, bowel or gallbladder, kidney stones	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
i.	Any other complaint requiring specialist's consultation or surgical or hospital treatment or investigations	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
j.	Any complaint or tendency that may necessitate such consultation or treatment in the future	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
k.	Any dimness of vision /cataract	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
l.	Any disease of ears or difficulty or interference with hearing	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
m.	Diabetes or any urinary disease	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
n.	Rheumatic fever	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
o.	Any cancer or malignant growth	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
p.	Any boil, cyst or wound which does not heal or improve despite treatment	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N

11. Claims experience for a minimum period of three years

Month/ year	Insurer	Premium Paid	Incurred Claims (reserved+ outstanding)

12. Has any Company

a. Declined to issue a policy to you? Y N

b. Declined to continue your Insurance? Y N

c. Not invited the renewal of your Policy? Y N

d. Imposed any restriction or special conditions? Y N

If so, please give name and address of each Company in respect of a, b, c, d above

13. Is this Insurance to be additional to any other Accidental Policy or Medical health insurance? Y N

If so give particulars of all other policies

a. Name and address of Company: _____

b. Number of persons covered under the Policy: _____

c. Benefits under the Policy: _____

d. Sum Insured: _____

e. Policy Number: _____

DETAILS OF THE RISK

14. Policy Period: (DDMMYYYY) Policy End Date:

15. Please indicate Sum Insured under the Policy for following sections

a. Hospital Cash Amount of Daily Allowance

- Option 1 500 per day
 - Option 2 1000 per day
 - Option 3 1500 per day
 - Option 4 2000 per day
 - Option 5 2500 per day
 - Option 6 3000 per day
- b. Number of days cover required for
- 15 days
 - 30 days
 - 45 days
 - 60 days
 - 90 days
 - 180 days

16. Premium Details

Basic Premium: (Rs)

Less: Discount (if any): (Rs)

Net Premium: (Rs)

Add: Service Tax* and Education CESS (as applicable): (Rs)

Total payable premium: (Rs)

* Service Tax is subject to change as per change in Tax Laws

DECLARATION

- "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.
- 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.
- 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.
- 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.
- 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."

Dated at _____ this _____ day _____ of _____ 20 _____

Please Note: The liability of the company does not commence until the acceptance of the proposal has been formally intimated by the Company.

PROHIBITION OF REBATE -- Section 41 of the Insurance Act 1938

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 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 rebates as may be allowed in accordance with the published prospectuses or tables of the Insurer. Any person making default in complying with the provisions of this section shall be punishable with fine which may extend to Five Hundred Rupees.

Proposer's Signature

USE IF FILLED BY SCRIBE

(APPLICABLE ONLY WHERE FORMS FILLED IN BY A SCRIBE* OR FOR FORMS SIGNED IN VERNACULAR LANGUAGES)

I, _____ (Full Name), have explained to the Proposer, that the answers to the questions for form the basis of the contract for _____ Policy between the Company and the Proposee Policyholder and that if any untrue statement is contained therein the Company shall have the right to vary the benefits which may be payable and further, if there has been a nondisclosure of a material fact the policy may be treated as void and all premiums paid under the policy may be forfeited to the Company. I also confirm that the Proposee Policyholder has signed / affixed his/her right thumb impression in my presence.

I, the Proposee Policyholder declare that the contents in the proposal form and documents have been fully explained to me and I have fully understood the significance of the proposed contract.

ADDRESS OF SCRIBE

City/Village: _____

State: _____

Place: _____

Pin: _____

Date: _____

Signature of the Scribe _____

*Scribe is a person not connected with the Company

Signature / Right Thumb Impression of the Policyholder Proposer

Signature of Agent / Broker as witness

USE IF FILLED BY OTHER THAN SCRIBE

IN CASE THE PROPOSED INSURED/PROPOSER IS ILLITERATE OR IS SIGNING IN VERNACULAR OR IF FORM HAS BEEN FILLED BY AGENT/EMPLOYEE / SPECIFIED PERSON/ BROKER ON BEHALF OF THE PROPOSER/PROPOSED INSURED

I, _____ (name of the Agent/Specified Person/Broker/Employee) _____ (Agent/Specified Person/Broker/Employee Code) hereby declare that I have read & explained the contents of the proposal form to the Proposed Insured/ Proposer in language and that I have read out to the Proposed Insured/ Proposer the answers to the questions dictated by the Proposed Insured/Proposer. The information/answers filled in the proposal form by me on behalf of the Proposed Insured/ Proposer are exact replication of the information/answers provided to me by the Proposed Insured/Proposer and that the Proposed Insured/ Proposer has signed/affixed his/her thumb impression on the proposal form after fully understanding the contents thereof. I further declare that there is no addition/ deletion/alteration done by me to the information/answers provided by the Proposed Insured/ Proposer.

Signature of Agent/Specified Person/Broker/Employee

Signature/Thumb Impression of Proposed Insured/ Proposer

Witness Details:

Name: _____

Signature: _____

ID Proof Type: _____

ID Proof Number: _____

Universal Sompo General Insurance Co. Ltd.

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Toll Free Nos 1800224030 (VTNL)/ 8002004030 (Reliance) Direct Nos : 022 27639800 (VTNL)/ 39133700 (Reliance)

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