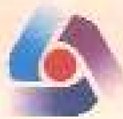

Universal Sompo General Insurance Co. Ltd.

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

Regd. Office : Unit No 401, 4th Floor, Sangam Complex,127, Andheri Kurla Road, Andheri (E), Mumbai - 400059, Maharashtra.
Fax# 022 -29211844. Email: contactus@universalsompo.com.

SWARNA GRAMIN BIMA YOJANA (INDIVIDUAL) 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 ☐ Voter ID card Number ☐

Any other (please specify): ______

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

If yes, please provide details as per below format :

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

7. Please provide details of Nominee under the Policy

Name of the Nominee : ______

8. 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 : ______

11. Do you/ your family members have any infirmity/sickness or any medical complaint? Y☐ N☐

Please provide details if answer to the above is yes.

12. Have you sufferd from any one of the following

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

13. Claims experience for a minimum period of three years

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

14. 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

15. 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

16. Policy Period: (DDMMYYYY)

Policy Start Date : Policy End Date:

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

a. **Personal Accident**

50000 ☐ **75000** ☐ **100000** ☐ **125000** ☐ **150000** ☐ **200000** ☐

b. **Critical Illness and Surgical Procedure**

50000 ☐ **75000** ☐ **100000** ☐ **125000** ☐ **150000** ☐ **200000** ☐

Which of the following Critical Illnesses and Surgical Procedures you want to cover?

Option 1 ☐	Option 2 ☐	Option 3 ☐
Cancer of Specified Servirity	Option 1+	Option 2+
First Heart Attack of specified severity	Multiple Sclerosis with persisting symptoms	Motor Neurone Disease with Permanent Symptoms
Open Chest CABG	Stroke resulting in permanent symptoms	Major Organ /Bone Marrow Transplant
Open Heart Replacement	Permanent Paralysis of Limbs	
Coma of Specified Severity	Kidney Failure requiring regular dialysis	
Cancer of specified severity	Multiple Sclerosis with persisting symptoms	

c. Hospital Cash

	Option 1	Option 2	Option 3		
Amount of Daily Allowance :	250 per day ☐	500 per day ☐	1000 per day ☐		
b. Number of days cover required for :	15 days ☐	30 days ☐	45 days ☐	90 days ☐	180 days ☐

18. Please mention the extensions you want to opt for under the Policy
    Extension 1: Cover for pre-existing diseases Y☐ N☐

19. Premium Details

Basic Premium :	(Rs)
Extension Premium :	(Rs)
Total Premium :	(Rs)
Less: Discount (if any) :	(Rs)
Net Premium :	(Rs)
Add: Service Tax* and Education CESS (as applicable) :	(Rs)
Total payable premium	(Rs)

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 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
DECLARATION
(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 form the basis of the contract for ____________ Policy between the Company and the Propose 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 Propose Policyholder has signed / affixed his/her right thumb impression in my presence.

I, the Propose 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: ____________