# HEALTH CARE PLUS INSURANCE PROPOSAL FORM

**For Official Use Only**

Proposal No. : HCP

Intermediary ID : _____ Intermediary Name : _____

Branch Name : _____ Deal No. : _____

**GUIDELINES FOR COMPLETION OF THE FORM (To be filled by proposer)** **BLACK OR BLUE BALL PEN & CAPITAL LETTERS ONLY**

Please ensure that the details furnished are correct and complete in all respects. The company's decision for acceptance of the risk will be on the basis of information provided below. In case of any doubt regarding the information to be provided, please seek advice from your insurance advisor or agent. Please attach additional sheets if required. The policy issued under this plan will be valid for one / two years as applicable (auto renewal basis).

## PROPOSER INFORMATION

Proposer's Name (please leave a space after each part of name)

Mr. / Ms. / Dr. :

Date of Birth : D D / M M / Y Y Y Y Gender : M F Marital Status : Single ☐ Married ☐

Occupation : Salaried ☐ Self Employed ☐ Professional ☐ Others ☐ Details

Annual Income : Less than 5 Lacs ☐ Between 5 - 10 Lacs ☐ Between 10 - 20 Lacs ☐ 20 Lacs and above ☐

PAN No. :

Correspondence Address :

Landmark :

City : State : Pin code :

Landline Number (with STD Code) : Mobile Number* :

Fax Number (with STD Code) : E-mail address :

Permanent Residence Address :

Landmark :

City : State : Pin code :

*Kindly provide the details to enable us to serve you better

## FAMILY PHYSICIAN DETAILS

Name of Physician : F I R S T M I D D L E L A S T

Landline Number (with STD Code) : Mobile Number :

Fax No. :

## DETAILS OF PERSONS TO BE INSURED

| Insured No. | Full Name (First, Middle, Last) | Gender (M/F) | Date of Birth (DD/MM/YY) | Relationship with Proposer | Height (feet/inches) | Weight (kgs) |
|---|---|---|---|---|---|---|
| Insured 1 | | | | | | |
| Insured 2 | | | | | | |
| Insured 3 | | | | | | |
| Insured 4 | | | | | | |

## DETAILS OF INSURANCE / PLAN (Please Tick)

| Tenure | | Age Band | No. of Individuals | | | |
|---|---|---|---|---|---|---|
| ☐ 1 Year | ☐ 2 Years | ☐ 5 - 65* Years | ☐ 1 | ☐ 2 | ☐ 3 | ☐ 4 |
| **Sum Insured** | ☐ 5 Lacs; Deductible 2 lacs | | ☐ 8 lacs; Deductible 3 lacs | | ☐ 10 lacs; Deductible 4 lacs | |

* Medical report required for person aged 56 years and above. All family members to have same policy tenure and plan.

## EXISTING / PREVIOUS INSURANCE DETAILS

Is any proposer or the person proposed, already insured under a plan with ICICI Lombard GIC Ltd ? Yes ☐ No ☐

If yes please indicate below the Policy number(s) (Please mention proposal number in case of pending proposal.)

| Insured Name | Policy No. / Proposal No. | Period Of Insurance | Sum Insured | Claims lodged during policy period (Yes /No) |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |

## MEDICAL AND LIFESTYLE INFORMATION

**SECTION A: Have 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 and provide details in Section B**

| | Yes/ No | Insured 1 | Insured 2 | Insured 3 | Insured 4 |
|---|---|---|---|---|---|
| 1. Hypertension History : | Y N | | | | |
| a) Duration | | | | | |
| b) Medications | | | | | |
| c) Dosage | | | | | |
| 2. Diabetes Mellitus History : | | | | | |
| a) Type I or Type 2 | Y N | | | | |
| b) Duration | | | | | |
| c) Medications | | | | | |
| d) Dosage | | | | | |

| | Yes/ No | Insured No | Diagnosis Since (In Years) |
|---|---|---|---|
| 3. Cardiovascular, Chest Pain, Any Heart, any artery/vein Disease | Y N | 1 2 3 4 | 1 2 3 4 5 - 10 > 10 |
| 4. Renal Failure, Stone, Dialysis Or Any Other Kidney/Urinary Tract Or Prostate Disease | Y N | 1 2 3 4 | 1 2 3 4 5 - 10 > 10 |
| 5. Arthritis, Spondylosis, Joint Pain, Joint Replacement Or Any Other Disorder Of The Muscle/ Bone/ Joint | Y N | 1 2 3 4 | 1 2 3 4 5 - 10 > 10 |
| 6. Tuberculosis, Asthma, Bronchitis, COPD, Or Any Other Lung / Respiratory Disease | Y N | 1 2 3 4 | 1 2 3 4 5 - 10 > 10 |
| 7. Liver Disease Or Any Other Gastro Intestinal Or Gallbladder Disease | Y N | 1 2 3 4 | 1 2 3 4 5 - 10 > 10 |
| 8. Tumor-Benign Or Malignant, Any Growth/Cyst, any Cancer | Y N | 1 2 3 4 | 1 2 3 4 5 - 10 > 10 |
| 9. Stroke, Epilepsy, Paralysis, Or Any Other Brain/ Nervous System Disease | Y N | 1 2 3 4 | 1 2 3 4 5 - 10 > 10 |
| 10. Fibroid, Cyst/ Fibroadenoma, Bleeding Disorder, Pelvic infection Or Any Other Gynaecological / Breast Disorder | Y N | 1 2 3 4 | 1 2 3 4 5 - 10 > 10 |
| 11. Undergone any hospitalisation/illness/surgery/symptoms /habit (please specify in section B) | Y N | 1 2 3 4 | 1 2 3 4 5 - 10 > 10 |

| SECTION B: Name and details of Illness / Medicine / Test / Surgery / Diopter grade (for questions answered as yes in SECTION A above) | Date of Last Consultation | Doctor's Name | Hospital Name & Phone No. |
|---|---|---|---|
| Insured 1 : | | | |
| Insured 2 : | | | |
| Insured 3 : | | | |
| Insured 4 : | | | |

## PAYMENT DETAILS

Payment Option: Cheque ☐ DD ☐ Cheque / DD Number ☐☐☐☐☐☐ Dated : D D / M M / Y Y Y Y

Premium Amount : (applicable as per chart in next page) ☐☐☐☐☐☐☐

Amount in words : _____

Bank _____ Branch _____

☐ Yes, I would like to opt for ECS Payment option for Policy Renewal.

I/we hereby declare and undertake that the amount paid by me/us as premium for the aforementioned policy is out of my/our lawful and declared source of income

Signature of proposer : _____ Date : D D / M M / Y Y Y Y

## POLICY TERMS & CONDITIONS

Premium amount as applicable for the plan, All family members to have same policy tenure and plan

☐ Tenure - 1 Year

| Plans / No. of individuals coverd | Number of Individuals | | | |
|---|---|---|---|---|
| Age Band - 5 Years to 65 Years | 1 | 2 | 3 | 4 |
| Plan 1 : Deductible of 2 lacs; Sum Insured of 5 lacs | 4,494 | 7,640 | 10,787 | 13,483 |
| Plan 3 : Deductible of 3 lacs; Sum Insured of 8 lacs | 3,090 | 5,253 | 7,416 | 9,270 |
| Plan 5 : Deductible of 4 lacs; Sum Insured of 10 lacs | 2,247 | 3,820 | 5,393 | 6,742 |

☐ Tenure - 2 Years (auto renewal basis)-

| Plans / No. of individuals coverd | Number of Individuals | | | |
|---|---|---|---|---|
| Age Band - 5 Years to 65 Years | 1 | 2 | 3 | 4 |
| Plan 1 : Deductible of 2 lacs; Sum Insured of 5 lacs | 8,539 | 14,517 | 20,494 | 25,618 |
| Plan 3 : Deductible of 3 lacs; Sum Insured of 8 lacs | 5,871 | 9,980 | 14,090 | 17,612 |
| Plan 5 : Deductible of 4 lacs; Sum Insured of 10 lacs | 4,270 | 7,258 | 10,247 | 12,809 |

(All prices are inclusive of Service Tax, Education Cess.) (All figures in ₹)

**Medical report required for person aged 56 years and above.**

## KEY EXCLUSIONS*

Pre Existing Illnesses, diseases contracted during first 30 days, any expense incurred prior / post Hospitalization, self-inflicted injury, suicide or attempted suicide, alcohol/ drug abuse, cost of spectacles/contact lenses, dental treatment, AIDS, treatment arising from or traceable to pregnancy and childbirth, miscarriage, abortion and its consequences, tests and treatment relating to infertility and invitro fertilization, certain specified diseases during first two years of the Policy.

*This is only an indicative list. For complete list refer to policy wording

## TERMS OF RENEWAL

a) The policy can be renewed under the then prevailing Health Care Plus Product or its nearest substitute approved by IRDA.
b) Premium payable on renewal and on subsequent continuation of cover are subject to change with prior approval from IRDA
c) This policy can be renewed up to a maximum age of 70years.
d) Addition of member only at the time of renewal.

## ELIGIBILITY

- Enrolment age for the eldest member proposed for insurance is from 5 years to 65 years.
- The proposer needs to be aged 18 years or above

## SCOPE OF COVER

The Policy provides indemnification of the Medical Charges incurred as an inpatient for a minimum period of 24 consecutive hours during Hospitalization which are in excess of the Deductible amount. Any pre and post Hospitalization charges shall not be considered as part of the Deductible amount. The Company is liable for the amount in excess of the Deductible amount upto a maximum of the Sum Insured under the Policy. Health Care plus policy gets triggered only when a single claim amount is more than the deductible amount."



## ELECTRONIC CLEARING SERVICE (Debit Clearing) MANDATE FORM

To,

Proposal No. **HCP**

ICICI Lombard General Insurance Company Ltd,
ICICI Lombard House, 414, Veer Savarkar Marg, Near Siddhi Vinayak Temple, Prabhadevi, Mumbai 400 025.
Ref : Authorization of Customer to remit funds/payments to ICICI Bank Ltd through Electronic Clearing Service

**Customer Information :**

a. Account Holder(s) Name (As appearing in the Bank Records) :

b. Bank Name :

c. Bank Branch Name :

d. Address :

e. Branch City :

g. Account Type : Savings ☐ Current ☐ Cash Credit ☐ Overdraft ☐

g. Account No. :

h. Ledger No. / Ledger Folio No. :

i. 9 Digit MICR Code :

**Declaration :**

I wish to avail of the Electronic clearing facility and hereby express my unconditional consent to debit premium for my Health insurance policy applied vide proposal form no. xxxxxxxxxxx through participation in Electronic Clearing System (ECS) . I, understand and agree that premium amount to be debited from my account may vary due to – change in age bracket of the senior most member insured under the policy, claims history in expiring policy, change in applicable premium rates by the insurer, taxes and other statutory levies as may be applicable from time to time.

(Please refer to sales brochure for approximate premium details due to change in age applicable at the time of renewal)

I, hereby declare that the particulars given are correct and complete. I understand and accept that the transaction will be effected on the due date as opted by me in this form (provided the day is a working day). If the transaction is delayed or not affected at all for reasons of incomplete or incorrect information, I/we would not hold the user institution responsible. I/We have read all the terms and conditions as are applicable for availing of this ECS Debit service from/through the user institution and agree to discharge the responsibility expected of me/us as a participant under the scheme.

I/We also hereby authorize representative of ICICI Lombard General Insurance Company Ltd. carrying this ECS Debit Mandate Form to get it verified and executed by my/our Bank.

## DECLARATION

I/ We have read and understood the terms and conditions of the Policy and confirm to abide by the same.

I/We hereby agree that the insurance coverage under the Policy will commence only on realization of full premium, receipt of complete medical reports (wherever applicable) and subject to medical underwriting approval by the Company. Receipt of proposal form by the Company shall not be construed as acceptance of proposal. Company in its sole discretion reserves the right to accept or reject any proposal without assigning any reasons thereof. I/We hereby declare that I/We will submit to medical examinations by the nominated doctors of the Company or undergo diagnostic or other medical tests, as suggested by the Company for its medical underwriting.

I/We hereby agree that the Company reserves the right to enquire from any physicians, nurse, hospital official or employee or any person, institution for all or any information regarding the medical history of the proposed and that the Company shall have the right to ask the proposed for the medical check-up.

I/We, the undersigned hereby declare that the above statements and particulars are true, accurate and complete and I/We declare and agree that this declaration and the answers given above shall be held to be promissory and shall be the basis of the contract between me/us and the Insurer.

I/We authorize the Company and their agents to exchange, share or part with all the information relating to my/ our personal and financial details with Government bodies / Regulatory Authorities/ Statutory bodies, or under court orders as may be required and I/We will not hold the Company and its agents liable for use of this information.

I/We agree that the Policy shall become voidable at the option of the Insurer, in the event of any untrue or incorrect statement, misrepresentation, non-description or nondisclosure in any material particular in the Proposal form/personal statement, declaration and connected documents, or any material information has been withheld by me/us or anyone acting on my/our behalf to obtain any benefit under this policy.

Signature of the proposer : _____ Place : _____ Date : D D / M M / Y Y Y Y

## IMPORTANT NOTES

- The information that you give to us on this proposal form or in any supplementary Information for or documentation supplied by you or on your behalf will influence our decision to offer insurance and the terms upon which to offer it. Further, any policy we issue will be based on what you have communicated to us. It is therefore important that your answer are complete and accurate in all respect.
- The question in this proposal are indicative rather then exhaustive. You must provide us with all information relevant to the risk to be insured, even if it is not the subject of a question in this proposal. If you are in any doubt as to what information should be given, you should liaise with your insurance advisor/ company.
- Acceptance of your proposal would be subject to receipt of complete medical reports(wherever applicable), medical underwriting and realization of full premium amount by the company and the insurance coverage will commence from the date of underwriting by the company.
- The list of exclusions/ inclusions and other policy details are indicative, for complete list and comprehensive details kindly refer policy wordings.

## STATUTORY WARNING

PROHIBITION OF REBATES (Under Section 41 of Insurance Act 1938)

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 five hundred rupees.

ICICI Lombard Health Insurance | Aapka Plan B

**Mailing Address:** ICICI Lombard General Insurance Company Limited, Interface Building No.11, 401/402 4th Floor, New Link Road Malad (W), Mumbai - 400064.
**Corporate Address :** ICICI Lombard General Insurance Company Limited, ICICI Lombard House, 414, Veer Savarkar Marg, Near Siddhi Vinayak Temple, Prabhadevi, Mumbai 400 025.
**Visit us at www.icicilombard.com • Mail us at customersupport@icicilombard.com**
Now One Number for all your Insurance needs 1800 2666 (Toll Free also accessible from your mobile)


012300PF/SC



I, hereby authorize ICICI Lombard General Insurance Co. Ltd. and their authorized service providers, to enable the ECS facility for my premium payments and in the instance of ECS debit dishonor, to re-debit my account with the mentioned bank to recover the premium payable.

_____ Primary Account Holder's Signature (If different from Policy Holder )

_____ Policy Holder's Signature

_____ Joint Account Holder's Signature 1

_____ Joint Account Holder's Signature 2

## FOR OFFICE USE ONLY

a. Proposal Form No. : **HCP** b. Customer ID : _____

For Use by Customer/Account Holder's Bank :

We hereby certify that the particulars of the customers furnished above are correct as per our records, and we hereby declare that a copy of this mandate form, duly complete and signed, has been submitted to us

Bank Stamp _____ Signature of Authorized Official of the Bank _____

Name _____ Branch : _____

Designation _____ Date : D D / M M / Y Y Y Y

**Disclaimer :**

- Subject to change in service tax rates / re-instatement charges and as per customer's request. ICICI Lombard GIC Ltd. shall debit the customer's bank account if the customer's policy and the ECS mandate are In Force and until the customer gives a written request for cancellation of ECS.
- Request for cancellation of ECS facility has to be provided 15 days prior to the due date or the same would be effective from the next premium due date.
- Requests for payment mode to change to ECS has to be provided 30 days prior to the due date or the same would be effective from the next premium due date.
- Data provided by the customer in the cheque copy and the proposal form may be used by the Company to complete the ECS mandate in case required information has not been filled.