

Group Hospi-Cash Connect Policy

Proposal Form

The acceptance of the proposal is subject to receipt of the total premium and realization of payment will be as per the policy terms and conditions. Kindly fill the form completely in CAPITAL LETTERS to help us to serve you better. The Company is under no obligation to accept this Proposal. Receipt of this Proposal by the Company along with the premium payment & medical reports, if applicable, does not tantamount to the acceptance of the Proposal by the Company and does not result in a concluded contract of insurance. Coverage is as per the terms and conditions of our Standard Policy Wordings. The Policy shall become voidable at the option of the Insurer, in the event of any untrue or incorrect statement, misrepresentation, non-description, failure to disclose or suppression of any material facts in response to the questions in the proposal form or on non-disclosure of any material particular.

1. Company/ Proposer Details

Company/Proposer Name:

Address:

Industry Type:

Contact Person:

Position:

Designated Email Address:

Fax:

Contact No/Mobile No:

2. Proposal Details

Business Type: New Own Renewal Other Renewal

Policy Type: Individual

Sum Insured: _____

Proposed Policy Period: From

d	d	m	m	y	y	y	y
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 To

d	d	m	m	y	y	y	y
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No of Primary Members: No of Dependents: Total Group Size:

Proposed Covers:

A. Basic Cover	Please tick (✓) the Proposed cover	Please mention the Limits Proposed
Daily Hospitalization Cash Benefit (DHC) OR		
Daily Hospital Cash (DHC)- Only Accidents Benefit		
B. Choose and Pick covers		
Double Accident Benefit (DAB)- in case of Hospitalization more than 3 days		

Double ICU Benefit (DIB) - Sickness		
Double ICU Benefit (DIB) - Accident		
Recovery Benefit		*Upto __ times of DHC limit
Convalescence benefit		*Upto __ times of DHC limit
Special care on Minor Surgeries		*Upto __ times of DHC limit
Special care on Major Surgeries		*Upto __ times of DHC limit
Restore Benefit		
Double Critical Illness Benefit (DCI)-Listed Critical Illnesses		
Day care Procedure Cash-Listed Procedures		
Wellness Program		
Special Limit		
Special Care		Available for the member upto 60 Years of age

*Can select maximum upto 15 times of DHC limit.

3. Proposed Insured(s) Details

Sr. No	Emp Code	Employee Name	Dependent Name	Relationship	DOB	DOJ	Pre Existing Disease	Designation	SI	Nominee Name & Relationship

(Individual member details to be furnished by way of Annexure I- A provided hereunder)

4. Previous/Existing Insurance Details (if any)

Year	Premium	Claim Details								Group Size
		Claims Paid		Claims O/s		Claims Rejected		Claims Closed		
		No.	Amount	No.	Amount	No.	Amount	No.	Amount	
Year 1										
Year 2										
Year 3										
Year 4										
Year 5										

5. Previous Policy Terms and Conditions

6. Additional Information (If any)

7. Payment details

Instrument type (Cash/Cheque/DD/Others)	Name of the premium payer	Bank Name	Cheque Date	Amount in Rs

Please make an A/C Payee Cheque / DD / Pay Order in favour of 'Liberty Videocon General Insurance Company Limited' only

For NEFT Payments, please fill the Bank details mentioned below:

Bank Name																			
Branch																			
City																			
Account No																			
IFSC Code																			

Account Type: Savings Current

AML Details:

Please provide Permanent Account Number (PAN) if premium amount exceeds Rs. 1 Lac _____

- I/We hereby declare that the premium for the said policy is paid out of the legally declared and assessed sources of my/our income OR
- I/we hereby declare that the premium is paid from the Bank Account of Mr. /Ms. _____ the payment is allowed under the Income Tax Act 1961, and there is insurable interest with the payee.

8. 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.”

Date

Signature of Proposer / Authorized signatory

Section 41 of the Insurance Act 1938 (4 of 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 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 prospectus or tables of the insurer'. Violations of Section 41 of the Insurance Act 1938, as amended -Any person making default in complying with the provisions of this section shall be liable for a penalty which may extend to ten lakhs

9. For Office use only

Intermediary Name:	Intermediary Code:
Sales Manager Name:	Sales Manager Code:

10. Acknowledgement

ApplicationNo:

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Date:

d	d	m	m	y	y	y	y
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We acknowledge with thanks the receipt of your application and amount by Cash/Cheque/Demand Draft/Others _____ of the amount of Rs. _____ dated _____ drawn on _____.

The Company will have no liability until the proposal is accepted by the Company and communicated so to the proposer and on receipt of full premium against the proposal.

Signature of the receiver & office Seal:

INSURANCE IS A SUBJECT MATTER OF THE SOLICITATION

Liberty Videocon General Insurance Company Limited
Registered Office: 10th Floor, Tower A, Peninsula Business Park, Lower Parel, Mumbai

Annexure I - A

Member Data

Sr. No	Emp Code	Employee Name	Dependent Name	Relationship	DOB	DOJ	Pre Existing Disease	Designation	SI	Nominee Name & Relationship

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Note : In case of additional member/s, please share all above detail in a separate document.