Oriental Insurance

THE ORIENTAL INSURANCE COMPANY LIMITED
Regd. Office: Oriental House, A-25/27,
Asaf Ali Road, New Delhi-110002
CIN No.U66010DL1947GOI007158

SAKSHAM SWASTHYA POLICY-ORIENTAL
PROPOSAL FORM

GUIDELINES FOR COMPLETION OF THE FORM

- This policy is specially designed for Persons with Disability, Mental Illness and Persons with HIV/AIDS.
- Persons with Disability shall be covered if 40% or more disability is certified by the Medical Board appointed by the government for certifying Disability as per the Disability Act 2016.
- Please answer all questions correctly and completely.
- Only Indian Nationals can be covered under this policy.
- Only one policy can be purchased for this product across all insurers.
- Note: The Coverage proposed for insurance is not covered until the proposal is accepted and premium Is paid and the same is realized by THE ORIENTAL INSURANCE COMPANY LIMITED.

Intermediary Details

Intermediary Name	
Intermediary Code	
Intermediary Contact Details	

Proposer Details':

Name															
Communication Address															
	City:						State:								
	Pin-code:						Landmark:								
Contact Details	Phone							Email							
Profession:	Salaried ❑ Self-Employed❑ Other❑ Details:														
Occupation and Nature of Business/ Work:															
PAN No./ form 60/61															
AADHAAR No.	x	x	x	x	x	x	x	x							
Date of Birth															
Gender	Male❑ Female ❑Other ❑														

Coverage Details:		
Policy Type	Individual Basis	
Policy period	1 year	
Period of Insurance	From DD/MM/YYYY to DD/MM/YYYY	
Sum Insured	400000❑ 500000❑	
Coverage opted:	Pre-existing HIV/AIDS ❑ Pre-existing Disability ❑ Pre-existing HIV/AIDS and Disability ❑	
Waiver of Co-payment opted	Yes ❑ No ❑	

Details of Persons to be Insured:

Sr No	**Name of the Insured**	**Nationali ty**	**Date of Birth**	**Age**	**Gender**	**Height**	**Weight**	**Occupation**	**Marital Status**	**Relation with Proposer**
1										

Nominee Details:

NAME	DATE OF BIRTH	AGE	RELATIONSHIP WITH INSURED

* Where Nominee is a minor, give the details of Appointee

NAME OF THE APPOINTEE	DATE OF BIRTH	AGE	RELATIONSHIP WITH INSURED

Previous/Existing Health Details of Insured:

Do you suffer from HIV/AIDS?	Yes/No	If Yes, please enclose a recent certificate of your current CD4 count(within past 30 days)
Current CD 4 count		
Has your CD4 Count gone below 500 in the past 4 years?	Yes/ No .(If yes when and How many times)	
Do you suffer from any other illness/ disease related to/ arising of/ associated to HIV/AIDS?	Yes /NO	If Yes, please give details:
Do you suffer from any disability as per the listed conditions mentioned below:	Yes/ No	If Yes, please enclose Disability certificate mentioning percentage of disability wherever applicable.

1 *Blindness*	2 *Muscular Dystrophy*
3 *Low vision*	4 *Chronic Neurological conditions*
5 *Leprosy Cured persons*	6 *Specific Learning Disabilities*
7 *Hearing Impairment (deaf and hard of hearing)*	8 *Multiple Sclerosis*

9. Locomotor Disability	10. Speech and Language disability
11. Dwarfism	12. Thalassemia
13. Intellectual Disability	14. Haemophllia
15. Mental Illness	16. Sickle Cell disease
17. Autism spectrum disorder	18. Multiple Disabilities including deaf/ blindness
19. Cerebral Palsy	20. Acid Attack victim
21. Parkinson's disease	
Do you suffer from any pre-existing illness other than Disability or HIV AIDS mentioned above? Yes ❑ No ❑ If Yes, please specify details and the number of years you are suffering:	
Do you have any other physical disability arising out of any illness ! disease condition?	
Any other previous medical details	

Previous/Existing Health Insurance details

Policy No. / Application No.	Insurer Name	Period of Insurance (from — to)	Sum Insured	Claims lodged during the preceding years
Do you have the same policy from any one or other insurer? Yes ❑ No ❑ If yes, Please share details below:				
Policy No	Insurer Name	Period Of Insurance	Sum Insured	Claims lodged during the preceding years

Electronic Insurance Account Details Section:

I want related information in —	
Physical Format- Yes/No	e-Format (electronic) as & when applicable- Yes/No

Choose your Insurance Repository (For those selecting e-Format) (a)NSDL Data Management Ltd. (b)CDSL Insurance Repository Ltd (c)Karvy Insurance Repository Ltd. (d)CAMS Repository Services Ltd
I have e Insurance Account & the No. is ----------------------------
My CKYC No. (Central Know Your Customer registry number) is (If available) --------------------------

Premium Payment Details

Name of Premium payer:	
Premium Payment Frequency:	Monthly I Quarterly / Half Yearly
Premium Amount (in INR)	
Instrument Type:	Cash/ Cheque/ Debit Card/ Credit Card/ Others: Please
Date (DD/MM/YYYY):-------------	Cheque no. ------
Bank Name: --------	Bank Account Number: --------
IFSC Code:---------	Branch Name: -------------

Bank Account Details For Process Of Refund Cheque will be issued in the name of the Proposer only.

In case of cancellation of policy, if premium was paid through credit card the refund amount would be credited to Credit Card account directly or refund will be paid through cheque. Please provide the following bank details and a copy of Cancelled Cheque if you opt for direct credit of refund/ claim into your bank account:(Cancelled Cheque should be of the same bank account in which the refund needs to be credited directly.

Name of Accountholder	
Cheque No	
Bank Name	
Branch Name	
Cheque Date	
Cheque Amount for	
Name as in Bank Account	
Bank Account No	
IFSC Code	
MICR Code	

Note: The Proposer agrees and undertakes to intimate in writing to THE ORIENTAL INSURANCE COMPANY LIMITED about any change in bank account details.

If ECS is selected, please submit the standing instruction form available at our branches.

Place: Signature of proposer:

Date:

AML Guidelines

I/ We hereby confirm that all premiums have been/ will be paid from bonafide sources and no premiums have been/ will be paid out of proceeds of crime related to any of the offence listed in Prevention of Money Laundering Act 2002. I/VVe understand that the Company has the right to call for documents to establish source of funds. The insurance Company has the right to cancel the insurance contract in case I am/ have been found guilty by any competent court of law under any statues, directly or indirectly governing the prevention of money laundering in India.

DECLARATIONS:

1. I 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 am 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 further declare that I 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 declare and consent to the company seeking medical information from any doctor or from a hospital who at any time 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 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.

Place:		Signature of Proposer:
Date:		Name of Proposer:____________________________

NOTE:

In case of death claims, the name of the beneficiary making claim, relationship with the insured and legal status is to be mentioned.

The claim for any of the insured person will be payable in the name of Proposer and discharge voucher signed by him will be considered valid. However, in the event of unfortunate demise of the Proposer during the course of policy period, the claim may be payable to the nominee declared by the Proposer in this form.

Nomination:

In the event of my death, I nominate.. (Name & Relationship with the Insured) in respect of the amount payable by the Oriental Insurance Company Ltd under this policy and I further declare that his receipt shall be sufficient discharge to the Company.

Signature of Proposer

Signature of Witness:

Name and address:

PROHIBITION OF REBATES (Section 41 of the Insurance Act 1938 provides)

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 shownon the policy nor shall anyperson taking out or renewing or continuing a policy accept any rebate exceptsuch rebate as may be allowed in accordance with the published prospectus or tables of the Insurer.

2. Any person making default in complying with the provisions of this section shall be liable for a penalty which may extend to Ten Lakh Rupees.

VERNACULAR DECLARATION:

(The Company requires that this proposal is completed by the proposer himself. However, if this is not possible as the proposer does not read, write or speak English, then this proposal form can be completed by

another person who can read, speak and write English and who is not connected to the company either as an agent/employee or InsuranceIntermediary)

I have explained the contents of this proposal to the proposer and done my best to ensure that the contents have beenfully understood by the proposer. I have accurately recorded the proposer's responses to the information sought by the proposal form and I have read the responses back to the proposer and he/she has confirmed that they are correct.

Name of the Witness:

Signature of the Witness Thumb Impression/Signature of the

Proposer:Date:

AGENT DECLARATION:

I,___________________________in my capacity as an Agent/ Insurance Advisor/ Specified Person of the CorporateAgent/ Authorized employee of the Broker/Relationship Officer, do hereby declare that I have explained all the contents of this Proposal Form, including the nature of the questions contained in this Proposal Form to the Proposerincluding statement(s), information and response(s) submitted by him/her in this Proposal Form to questions contained herein or any details sought herein will form the basis of the Contract of Insurance between the Company and the Proposer, if this Proposal is accepted by the Company for issuance of the Policy.

I have further explained that if any untrue statement(s)/ information/response(s) is/are contained in this Proposal Form/including addendum(s), affidavits, statements, submissions, furnished/to be furnished, the Company shall havethe right to cancel the policy at its discretion. Further, this declaration does not confirm issuance of policy or assumption of risk thereof.

Name of the Agent: Date: Place:____________

Agent Code: Signature of the Agent……………………….