

LIBERTY HEALTH CONNECT POLICY PROPOSAL FORM

PLANS: BASIC AND ELITE

Application No. : _____

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.

Proposer Details

	Last Name	First Name	Middle Name
Proposer (Mr / Mrs / Ms) :			
Address :			
City/Town :		State :	
District :		Pin Code :	
Telephone :		Mobile :	
E-mail :			

Nationality : _____ Marital Status : _____ Annual Income : _____ Educational Qualification : _____

Plan Details

Policy Type : ☐ Individual ☐ Family Floater Policy Tenure : ☐ 1 Yr ☐ 2 Yrs

If Family floater, then persons to be covered : ☐ 2 Adults ☐ 2 Adults + 1 Child ☐ 2 Adults + 2 Children ☐ 1 Adult + 1 Child ☐ 1 Adult + 2 Children
☐ 1 Adult + 3 Children

Sum Insured : ☐ 2 Lacs ☐ 3 Lacs ☐ 4 Lacs ☐ 5 Lacs ☐ 6 Lacs ☐ 7.5 Lacs ☐ 10 Lacs ☐ 15 Lacs Plan : ☐ Basic ☐ Elite

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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Proposed Insured(s) Details

	Proposed Insured I	Proposed Insured II	Proposed Insured III	Proposed Insured IV
Name				
Relationship with proposer				
Gender				
Date of Birth				
Height				
Weight				
Profession	<input type="checkbox"/> Salaried <input type="checkbox"/> Self Employed <input type="checkbox"/> Others : _____	<input type="checkbox"/> Salaried <input type="checkbox"/> Self Employed <input type="checkbox"/> Others : _____	<input type="checkbox"/> Salaried <input type="checkbox"/> Self Employed <input type="checkbox"/> Others : _____	<input type="checkbox"/> Salaried <input type="checkbox"/> Self Employed <input type="checkbox"/> Others : _____
Basic Sum Insured*				
Nominee Name				
Relationship of Nominee				
Nominee Address				

* Floater policy will have same Basic Sum Insured for all members

Is any insured(s) Politically Exposed Person or relative of Politically Exposed Person: ☐ Yes ☐ No If yes, please give details : _____

Medical & Lifestyle Information

Medical History: Please tick (✓) the relevant disease and provide details.

In case of No medical history please mention 'No' against the respective column of the Proposed Insured member.

Section A: Have any of the proposed insured ever suffered from / currently suffering from any of the following	Proposed Insured I	Proposed Insured II	Proposed Insured III	Proposed Insured IV
Hypertension, Chest Pain or any other cardiac disorder				
Tuberculosis, asthma or any other lung / respiratory disorder				
Kidney stone / failure, urinary tract / prostrate disorder				
Dizziness / stroke / paralysis / epilepsy or any brain / nervous system disorder				

Medical & Lifestyle Information

Medical History: Please tick (✓) the relevant disease and provide details.

Section A: Have any of the proposed insured ever suffered from / currently suffering from any of the following	Proposed Insured I	Proposed Insured II	Proposed Insured III	Proposed Insured IV
Diabetes / thyroid or any hormonal disorder				
Tumor - benign / malignant, any cyst / ulcer / growth				
Arthritis / spondylosis or any other bone / muscle / joint disorder				
Disease of the nose / throat / ear / eye / dental				
Anaemia / leukemia or any other blood disorder				
HIV / AIDS / any sexually transmitted disorder				
Psychiatric / mental illness or sleep disorders				
DUB, Fibroid, Cyst, Fibroadenoma or any other Gynaecological disorder, menopause & GPAL History (to be filled for female lives only)				

Please provide the details, in case any question in Section A (above) is ticked

Section B: Have any of the proposed insured persons

Been addicted to alcohol / narcotics / habit forming drugs or under any detoxication therapy				
Been under any regular medication (self / prescribed including hormones or OC Pills)				
Undertaken any lab tests like blood / urine / stool or any imaging tests like sonography / MRI / CT / X-Rays in the last 5 yrs				
Undertaken any surgery or advised any surgery in the last 10 yrs or is a surgery pending?				
Suffered from any other illness / disease / accident / injury				
Is any of the proposed insured pregnant? If yes please specify expected date of delivery				
Any complaint of diabetes, hypertension or any complication during current or earlier pregnancy?				

Please provide the details, in case any question in Section B (above) is ticked

Section C: Does any person proposed to be insured consume

Alcohol - Hard liquor / Wine / Beer (Please mention quantity in ml per week)				
Smoking (Please mention number of cigarettes per day)				
Pan Masala / Gutka (Please mention number of packets per day)				
Others (Please mention name & quantity per week)				

Additional Information (if any)

Previous / Existing Insurance Details (if any)

Is the proposer or the persons proposed, already insured under or proposed for a health insurance policy for in-patient hospitalisation with Liberty Videocon General Insurance Company Limited or any other insurance company? If yes, please indicate below the Policy / Application number(s) (Please mention application number in case of pending proposal)

Since when are you continuously insured?

Do you want us to consider these details for portability? ☐ Yes ☐ No

Policy No./ Appl No.	Insured Name	Insurance Company	From (date)	To (date)	Sum Insured	Cumulative Bonus if any earned	* Claim Details (If any)
			d d m m Y Y Y Y	d d m m Y Y Y Y			
			d d m m Y Y Y Y	d d m m Y Y Y Y			
			d d m m Y Y Y Y	d d m m Y Y Y Y			
			d d m m Y Y Y Y	d d m m Y Y Y Y			

*Please provide claim details

Payment Details

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

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

For NEFT Payments, please fill the details mentioned below:

Bank Details of the Proposed Insured :

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.

Checklist of Documents

Please check the following documents are attached along with the proposal form

1. ID Proof : Passport / PAN Card / Voter's Identity Card / Driving License / National Identity Number
2. Residence Proof : Telephone Bill / Electricity Bill / Bank Account Statement / Ration Card
3. Age Proof : Any proof of age
4. Renewal notices with claim details

For Portability cases

1. Photocopies of previous policy documents and endorsements
2. Portability Form

Important Note :

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

Agreement, Declaration & Authorization

Do you agree to our sharing of aforesaid information with other entities? ☐ Yes ☐ No

"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

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, shall be punishable with a fine which may extend to five hundred (500) Rupees.

Acknowledgement

Application No. : Date :

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.

Neither the submission to us of a completed proposal for insurance nor any payment for any policy sought obliges us to agree to issue a policy, which decision is and always shall be in our sole and absolute discretion. If we accept a proposal for insurance, it shall be subject to the policy terms and conditions and we shall have no liability to make any payment if premium is not received by us in full and on time, or is not realised or non-fulfillment of Pre Policy Check-up. If we do not accept the proposal, we will inform you and refund any payment received from you without interest within the next 30 days.

Signature of the Receiver & Office Seal : _____

Please Note: For more details on risk factors, terms and conditions please read sales brochure carefully before concluding a sale.

Call Toll Free No : 1800 266 5844

www.libertyvideocon.com