

KNOW YOUR CUSTOMER (KYC) DETAILS

Please provide your Central Know Your Customer registration number below.

CKYC Number

If CKYC Number is not available, please confirm below on the documents being shared by you (proposer) to comply with KYC guidelines. (Please tick)

1. PAN Card Copy (compulsory) 2. Form 60 (only if PAN is not available)
3. **Address Proof** Driving License Voter's Identity Card Passport Copy NREGA Card

 Any other officially valid document (please specify)
4. **Identity Proof (only for those submitting Form 60)** Driving License Voter's Identity Card Passport Copy NREGA Card

 Any other officially valid document (please specify)

Note - Address proof and Identity proof can be 2 different documents or 1 same document too.

COVERAGE SELECTION

1. Plan details

Policy Type: Individual Family Floater

If Family Floater*, number of persons to be covered _____ Adults _____ Children
(* - Max 2 Adults and 4 children)

2. Proposed policy term

Policy Tenure: 1 Year 2 Years 3 Years

3. Deductible and Sum Insured (Please Select)

Deductible	Sum Insured
5 lakhs	<input type="checkbox"/> 10 lakhs <input type="checkbox"/> 15 lakhs <input type="checkbox"/> 20 lakhs <input type="checkbox"/> 45 lakhs <input type="checkbox"/> 70 lakhs <input type="checkbox"/> 95 lakhs
10 lakhs	<input type="checkbox"/> 15 lakhs <input type="checkbox"/> 40 lakhs <input type="checkbox"/> 65 lakhs <input type="checkbox"/> 90 lakhs
15 lakhs	<input type="checkbox"/> 10 lakhs <input type="checkbox"/> 35 lakhs <input type="checkbox"/> 60 lakhs <input type="checkbox"/> 85 lakhs
20 lakhs	<input type="checkbox"/> 30 lakhs <input type="checkbox"/> 55 lakhs <input type="checkbox"/> 80 lakhs
25 lakhs	<input type="checkbox"/> 25 lakhs <input type="checkbox"/> 50 lakhs <input type="checkbox"/> 75 lakhs

Please select your choice of TPA (Third Party Administrator) to service your cashless claims.

- Paramount Health Services (TPA) Pvt Ltd. Medi Assist Insurance TPA Pvt. Ltd Raksha Health Insurance TPA Pvt. Ltd.

Note : The above is in compliance with E.No. IRDAI / Reg/15/166/2019. Insurance Regulatory and Development Authority of India (Third Party Administrators – Health Services) (Amendment) Regulations, 2019.

DETAILS OF PERSONS TO BE COVERED

Sl. No	Insured Name (First, Middle, Last)	Gender Male / Female / 3 rd Gender	Date of birth	Relationship with proposer
1.			D D M M Y Y	
2.			D D M M Y Y	
3.			D D M M Y Y	
4.			D D M M Y Y	
5.			D D M M Y Y	
6.			D D M M Y Y	

OPTIONAL COVER

1. Reduction in Pre-Existing Disease waiting period from 36 months to 24 months YES NO

Nomination

In the event of the death of the proposer any payment due under the policy shall become payable to the nominee proposed in the form. The receipt of the proceeds by such nominee would be sufficient discharge to the company. Nominee for all other persons proposed to be insured shall be the proposer himself/herself. Following section to be filled by the proposer:

Nominee Name (First, Middle, Last)	Relationship with the proposer	Address and contact details of Nominee
		Address
		Phone Number

Electronic Insurance Account number

Would you like to open an Electronic Insurance Account with any Insurance Repository? YES NO

If yes, please furnish the below details.*

Insurance Repository Name

*Account will be opened with your Name / DOB / Address as mentioned in this proposal form.

If you already have an Electronic Insurance Account, please share the below details

Account Number

Account Name

Insurance Repository Name

4. Medical questions

Please answer the below mentioned questions accurately to the best of your knowledge in respect of each person proposed to be insured. If the answer to any of these questions is Yes, please provide the complete details in the table for additional medical information (Important – You must answer these questions truthfully.)

Please ensure that you are fully informed about the standard waiting periods and permanent exclusions that apply to this product.

Questions (please answer Yes/No)

Sl. No	Details	Insured 1	Insured 2	Insured 3	Insured 4	Insured 5	Insured 6
1	Have you or other family members proposed, ever suffered or are suffering from any Pre-Existing Disease (PED) (except as listed in Question 2) which have been diagnosed and for which you have been treated or taking continuous treatment or medication, Within the last 4 years, prior to this application? If 'Yes' please specify	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO

Questions (please answer Yes/No)

Sl. No	Details	Insured 1	Insured 2	Insured 3	Insured 4	Insured 5	Insured 6
2	Have you or other family members proposed, ever suffered from or are currently suffering from or under regular treatment for any major Illness like Sarcoidosis, Cancer, Heart Ailment Congenital heart disease and valvular heart disease, Heart Surgery like Angioplasty, Coronary Artery Bypass Surgery, Cerebrovascular disease (Stroke), Inflammatory Bowel Diseases, Chronic Liver diseases, Pancreatic diseases, Chronic Kidney disease, Hepatitis B, Alzheimer's Disease, Parkinson's Disease , Demyelinating disease, HIV & AIDS, Loss of Hearing, Papulosquamous disorder of the skin, Avascular necrosis (osteonecrosis), any major Organ Failure, Genetic disorder like Down Syndrome, Huntington's Disease etc? If 'Yes' please specify	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO

Note: Basis the response of above questions your case may be referred to Medical Underwriting.

5. Additional Medical Information

If you have answered yes to any of the questions in section 4, please give full details here. If you need more space please use extra sheets. If you are unsure whether any details are relevant, please include them.

Details	Insured 1	Insured 2	Insured 3	Insured 4	Insured 5	Insured 6
Name of illness/injury suffering from or suffered in the past						
Date of first diagnosis (Month & Year)						
Treatment/medication received/receiving						
Treatment outcome (fully cured/partially cured/ ongoing, etc)						

Note: Company may apply an exclusion based upon the declarations made in the proposal form and the health status of the members proposed to be insured.

Any exclusion, if applicable, shall be suitably intimated to the proposer based on the assessment of the proposal form and medical tests.

6. Payment Details: Please tick (✓) payment option

Premium Amount (₹) (In words _____)

Cash
 Cheque/NEFT/DD Payment Option:
Cheque/NEFT/DD Amount (₹) Cheque/NEFT/DD Number

Cheque/NEFT/DD Date Bank

For Auto-debit facility, you are required to submit Auto-debit authorization form separately.

For Cheque/DD (Payable in favour of Royal Sundaram General Insurance Co. Ltd)

7. Bank Account Details:

For payment of claims/refund through direct bank transfer, please provide the following details: (please enclose a cancelled cheque along with the proposal form)

Name of Bank _____ Branch _____ City _____

IFSC Code Account Number

Account Holder's Name

Sign Here X _____ Place : _____

Signature of Applicant

Intermediary Declaration

I, _____ (Full Name) in my capacity as an Insurance Advisor/Specified Person of the Corporate Agent/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 Proposer including statement (s), information and responses(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 have the right to vary the benefits which may be payable and furthermore, if there has been a non-disclosure of any material fact, the Policy issued to his/her favour pursuant to this Proposal may be treated by the Company as null and void and all premium paid under the Policy may be forfeited to the Company.

License No./ID (Advisor/Corporate Agent/Broker/Relationship Officer)

Date :

Signature of the Insurance Advisor : _____

SECTION 41 OF THE INSURANCE ACT, 1938 - PROHIBITION OF REBATES

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 continuing the policy accept any rebate except such rebate as may be allowed in accordance with the published prospectus or tables of the Insurer.
2. If any person fails to comply with sub-regulation (1) above, he shall be liable to payment of a fine which may extend to Ten Lakh Rupees.



Royal Sundaram

General Insurance

Royal Sundaram General Insurance Co. Limited

Vishranthi Melaram Towers, No. 2 / 319, Rajiv Gandhi Salai (OMR), Karapakkam, Chennai - 600097.

Registered Office: 21, Patullos Road, Chennai - 600 002.

Royal Sundaram IRDAI Registration No.102 | CIN: U67200TN2000PLC045611

☎ 1860 425 0000 | ✉ customer.services@royalsundaram.in | 🌐 www.royalsundaram.in

Advanced Top Up Health Insurance Plan



Proposal Form No.

ACKNOWLEDGEMENT

Date

D	D	M	M	Y	Y	Y	Y
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We acknowledge with thanks the receipt of your proposal and amount by Cash/Cheque/NEFT/DD/Others _____ of
amount of ₹. _____ dated _____
drawn on _____

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 whatsoever if premium is not received by us in full and in time or is not realized. If we do not accept the proposal, we will inform you and refund the payment, if any, received from you without interest.

Signature of the receiver and office seal



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