Proposal No.

SMART CASH PLAN
HEALTH PROPOSAL FORM

Royal Sundaram General Insurance

Intermediary Code:_____ Branch Name:_____ Branch Code:_____

PLEASE ENSURE THAT ALL QUESTIONS IN THE FORM ARE ANSWERED IN CAPITAL LETTERS. PLEASE TICK ☑ IN THE RELEVANT BOXES. ALL DETAILS ARE MANDATORY.

Tenure Opted: ☐ 1 Year ☐ 2 Years ☐ 3 Years

Please select your suitable plan. If you opt for different plans for different insured persons please mention the chosen plan for each of the insured person in "Details of persons to be covered" section.

☐ Silver Plan ☐ Gold Plan ☐ Platinum Plan

Optional Benefit ☐ Personal Accident

PROPOSER DETAILS

Please fill up this form in CAPITAL LETTERS for yourself and each proposed insured person

☐ Mr. ☐ Mrs. ☐ Miss ☐ Others _____ Gender ☐ Male ☐ Female ☐ 3rd Gender PAN Number

Name of the Proposer
First Name Middle Name Last Name

Address for Correspondence

City State

Landmark Pincode

Telephone Mobile* /

Date of Birth D D M M Y Y Y Y Marital Status: ☐ Married ☐ Single Nationality: ☐ Indian ☐ NRI ☐ Foreigner

Education Qualification ☐ Lesser than matriculation ☐ Matriculation ☐ Graduate ☐ Post Graduate ☐ Professional Course

Occupation ☐ Salaried ☐ Self employed ☐ Student ☐ House wife ☐ Others

If salaried, specify designation_____

If self employed, specify business/occupation_____

Annual Gross Income (₹) ☐ Up to 5 lakhs ☐ 5 to 10 Lakhs ☐ 10 to 25 Lakhs ☐ 26 to 50 lakhs ☐ 50 Lakhs to 1 Crore ☐ Above 1 Crore

E-mail*

Ayushman Bharat Health Account (ABHA)

Nominee Name _____ Nominee's relationship to proposer _____

Is your nominee also proposed for cover in this policy ☐ Yes ☐ No

Please specify if you fall under any of the listed categories. (please tick and give details where ever required)

1. ☐ Non Resident Indian (NRI)
2. ☐ Member of any Trust: ☐ Charities ☐ Non-Government Organisation (NGO)
3. ☐ Politically Exposed Person (PEP): ☐ Senior Politician ☐ Senior Government ☐ Judicial ☐ Military Officer
   ☐ Senior Executive of State Owned Corporation ☐ Important Political Party Official
   ☐ Head of State or of Government.

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.

DETAILS OF PERSONS TO BE COVERED

Sl. No	Name (First, Middle, Last)	Date of birth	Gender	Relation to proposer	Profession/trade/ occupation	Smart Cash Sum Insured	Plan	Personal Accident Sum Insured	Smart Cash Premium	Personal Accident Premium
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								

Total Premium	
Family Discount (if applicable)	
Final Premium	

Please provide Nominee Details for members opting for a Personal Accident cover

Sl. No	Name (First, Middle, Last)	Nominee Name	Nominee Relationship (with the insured person)	Sl. No	Name (First, Middle, Last)	Nominee Name	Nominee Relationship (with the insured person)
1				4			
2				5			
3				6			

Have you or other family members proposed, ever suffered or suffering from any symptom of physical or mental diseases/illnesses/infirmity or medical conditions or any congenital anomalies or developmental anomalies or any other medical complaints or sustained any accident and / or diagnosed with any disease / illness or have received any treatment or undergone any surgery for any diseases / illness?

If yes, give details for each person proposed

Sl. No	Name of the Proposed Person	Nature of illness/disease/injury	Date first diagnosed	Treatment taken/now being taken/surgery done	Name of the attending medical practitioner with phone number
1					
2					
3					
4					
5					
6					

Are there any additional facts affecting the proposed Insurance which should be disclosed to Insurers?: .....

Have you ever suffered from or currently suffering from or under treatment for the following?

Details	Member 1	Member 2	Member 3	Member 4	Member 5	Member 6
High blood sugar / Diabetes	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
Heart Disease	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
Blood Pressure (Hypertension) / Stroke	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
Chronic Obstructive Pulmonary disease	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
Any type of Cancer	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
Any type of Arthritis	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
Seizure disorder/epilepsy	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
Kidney / Liver problems / Any type of Hepatitis	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO

Do you have any other Health Insurance / Hospital Cash / Personal Accident Insurance Policies under any other schemes including credit cards, employee schemes etc. (from Royal Sundaram or any other company)	☐ YES ☐ NO
If Yes, please give the following details	

Health / Hospital Cash / PA	Name of the Person covered	Name of the Company	Policy Number	Period of Insurance	Sum Insured

I/We declare that persons proposed include my family members only and they are not engaged in any high risk occupation. I have given explicit information of instances of pre-existing diseases and understand that such pre-existing medical conditions will be covered depending on whether the plan chosen by me covers the same after the completion of the applicable waiting period as per the policy terms and conditions. I understand that the premium if paid by cash will not be eligible for deduction under Section 80D of the Income Tax Act, 1961.

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. I understand and note that this proposal form shall form the basis of contract and any statement, answer, particulars which are incorrect or untrue shall entitle the Insurers to deny any liability under the Policy. I hereby agree to enroll myself and/or my dependants to the policy chosen by me.

I / We understand that acceptance of proposal shall be based purely on the underwriting guidelines of the company.

Date D D M M Y Y Place:_____ Signature or thumb impression of the Proposer_____

FURTHER DECLARATION WHERE SCRIBE IS INVOLVED (COMPULSORY FOR ALL DECLARATIONS SIGNED IN ANY VERNACULAR LANGUAGE)

I _____(full name of scribe) have explained to the proposer the contents of this form & that if any untrue statement is contained herein, the proposer and/or the heirs, administrators, assignees of the proposer shall not be entitled to receive any benefits, including, inter alia, benefits under any insurance policy procured on the faith of this form.

Signature of the Scribe: _____ Signature of thumb impression of the Proposer:_____

Name and address of the witness: _____

_____

Signature of the witness: _____ Date D D M M Y Y Place:_____

Payment Details: Please tick (√) payment option Premium Amount (₹)

☐ Cash

☐ **Cheque/DD Payment Option:** Cheque/DD Number

Cheque/DD Date D D M M Y Y Bank

☐ **Card Payment Option :**

Charge the premium to my ☐ Credit Card ☐ Debit Card Date of Expiry M M / Y Y

Visa / Master Card No.

Name of the Bank

I hereby authorize Royal Sundaram General Insurance Co. Limited to charge applicable premium for me and my family members policy to my above mentioned Visa/Master Card.

Please provide your bank account details to enable us to make a direct refund of premium in to your account, in the event of you opting for policy cancellation. Refund of premium will be as per the policy terms and conditions.

Name of Bank _____ Branch _____ City_____

IFSC Code Account Number

Sign Here
X_____
Signature of Applicant

Place : _____ Date : D D M M Y Y Y Y

Please attach medical reports wherever applicable. Acceptance of proposal is subject to the underwriting guidelines of the company.

For Office Use Only

Customer ID :_____ Policy No. :_____

Issuing Office :_____

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 renewing 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 rupees ten lakhs.

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**