

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. Policy Type: Individual Family Floater **2. Proposed Policy Tenure:** 1 Year

If Family Floater*, number of persons to be covered: Adults: _____ Children: _____ (* - Maximum 6 Adults)

Are you covering all children YES NO Note: Proposer has to be mandatorily covered in the policy

3. Sum Insured 1 Lakh 1.5 Lakhs 2 Lakhs 2.5 Lakhs 3 Lakhs 3.5 Lakhs 4 Lakhs 4.5 Lakhs 5 Lakhs
 5.5 Lakhs 6 Lakhs 6.5 Lakhs 7 Lakhs 7.5 Lakhs 8 Lakhs 8.5 Lakhs 9 Lakhs 9.5 Lakhs 10 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 F.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)	Date of birth	Gender	Relationship with proposer	Height (cm)	Weight (kg)	Profession/trade/ occupation
1.		D D M M Y Y Y Y	<input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> 3 rd Gender				
2.		D D M M Y Y Y Y	<input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> 3 rd Gender				
3.		D D M M Y Y Y Y	<input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> 3 rd Gender				
4.		D D M M Y Y Y Y	<input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> 3 rd Gender				
5.		D D M M Y Y Y Y	<input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> 3 rd Gender				
6.		D D M M Y Y Y Y	<input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> 3 rd Gender				
7.		D D M M Y Y Y Y	<input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> 3 rd Gender				
8.		D D M M Y Y Y Y	<input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> 3 rd Gender				
9.		D D M M Y Y Y Y	<input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> 3 rd Gender				
10.		D D M M Y Y Y Y	<input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> 3 rd Gender				

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

If yes, please mention account number

4. Medical Questions

Please answer the below mentioned questions accurately to the best 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 the Arogya Sanjeevani Policy, Royal Sundaram General Insurance Co. Limited.

Sl. No	Questions (please answer Yes/No)	Proposed Insured Name(s)									
		1	2	3	4	5	6	7	8	9	10
1	Within the last 2 years have you consulted a doctor or healthcare professional? (other than Preventive Health Check-up or Pre Employment Health Check-up)	<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	<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
2	Within the last 2 years have you undergone for any detailed investigation (e.g. X-ray, CT Scan, biopsy, MRI, Sonography, etc) (other than Preventive Health Check-up or Pre Employment Health Check-up)	<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	<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
3	Within the last 5 years have you been to a hospital for an operation/medical treatment?	<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	<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
4	Do you take tablets, medicines or drugs on a regular basis?	<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	<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
5	Within the last 3 months have you experienced any health problems or medical conditions which you/proposed insured person have/has not seen a doctor for	<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	<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
6	Have any of the person proposed to be insured ever suffered from or taken treatment, or hospitalized for or have been recommended to take investigations/medication/surgery or undergone a surgery for any of the following – Diabetes; Hypertension; Ulcer/Cyst/Cancer; Cardiac Disorder; Kidney or Urinary Tract Disorder; Disorder of muscle/bone/joint; Respiratory disorder; Digestive tract or gastrointestinal disorder; Nervous System disorder; Mental Illness or disorder, HIV or AIDS	<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	<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: In addition to the above, we may have additional questions for you or may ask you to undergo medical tests to complete your full medical assessment

Lifestyle questions:

Does any person proposed to be insured consume any of the following:

Substance		Proposed Insured Name(s)									
		1	2	3	4	5	6	7	8	9	10
Alcohol		<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	<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
	Quantity**										
	No. of Years										
Smoking		<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	<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
	Quantity (No./Day)										
	No. of Years										
Any other substance like Tobacco/Guthka/Pan/Pan Masala, etc		<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	<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
	Quantity (Pouch/Day)										
	No. of Years										
Narcotics		<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	<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
	Quantity										
	No. of Years										

If any of these habits has been in the past please mention the year of stopping it and the reason for doing the same _____ habit

(**Beer – No. of Pints per week, Wine & Spirit – ml/week)

5. Additional Medical Information

If you have answered yes to any of the questions in section 5, 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.

Substance	Insured 1	Insured 2	Insured 3	Insured 4	Insured 5	Insured 6	Insured 7	Insured 8	Insured 9	Insured 10
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/risk loading on the premium payable (based upon the declarations made in the proposal form and the health status of the members proposed to be insured). These loadings would be applied from the Policy Period State Date including all subsequent renewals with the company.

Any exclusion/loadings, if applicable, shall be suitably intimated to the proposer based on the assessment of the proposal form and medical tests. Proposer shall be required to pay the additional premium within stipulated time of such intimation. Company shall not be at any risk during this period. In the event of the decline of proposal due to non-receipt of this additional premium within the stipulated time or due to any reason, Company shall cancel your proposal and refund the premium amount after deducting charges as per policy terms and conditions.

GENERAL INFORMATION

1. Family Physician details:

Family Physicians name _____

Contact Number _____

2. Existing Insurance Details

Is the proposer or any of the persons proposed to be insured already insured under or proposed for a health insurance policy with Royal Sundaram General Insurance Co. Limited or any other insurance company YES NO

If YES, please indicate below the Policy/Application number(s). (Please mention application number in case of pending proposal)

Since when have you been continuously insured DD MM YYYY

Insured Name (First, Middle, Last)	Insurer Name	Policy No./ Application No.	Period of Insurance		Sum Insured (₹)	Claims details if any
			From	To		
			D D M M Y Y	D D M M Y Y		
			D D M M Y Y	D D M M Y Y		

If you want to avail the portability benefit from your existing insurance policy, please also submit to us (as an annexure to this proposal form) all the policy documents relating to the existing policy in addition to the information given above

3. Caution

You are obliged to make a full and frank disclosure of all facts material to the assumption of risk in relation to you and every person proposed to be insured that would influence our decision to issue policy or the terms on which it is issued and you must not misrepresent any information to us. The obligation continues until the policy is issued and does not end with the submission of this proposal form. If therefore, there is any change in the information given herein or new information comes to light before the policy is issued, then you must inform us of the same in writing without delay. If there is insufficient space to provide additional information, whether as requested or otherwise, then please attach an extra sheet duly signed. If the disclosure obligations are breached then may render any policy issued void.

4. Authorization for electronic policy fulfillment and service communications (Please read carefully and put a check mark against each before signing)

I hereby consent that the policy documents may be sent to me by email at _____ (Please provide us your e-mail id)

I hereby consent to and authorize Royal Sundaram General Insurance Co. Limited (Company) to make welcome calls, service calls or any other communication (electronic or otherwise) with respect to the proposed or existing policy of Company from time to time. (including Social Media like What'sApp)

Date :

Signature of the Proposer : _____

Place : _____

Name of Proposer : _____

5. 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/We undertake that the loadings applicable have been informed and understood by me.
- 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 Government and/or Regulatory authority.

Date :

Signature of the Proposer : _____

Place : _____

Name of Proposer : _____

6. Vernacular Declaration

I hereby declare that I have fully explained the contents of the proposal form and all other documents incidental to availing the health insurance from Royal Sundaram General Insurance Co. Limited to the proposer in the language understood by him/her. The same have been fully understood by him/her and the replies have been recorded as per the information provided by the proposer and the replies have been read out to fully understood and confirmed by the proposer.

Declarants Name

Relationship with proposer

Signature of declarant : _____

Signature of applicant in vernacular : _____

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

Premium Amount (₹)

Cash

Cheque/NEFT/DD Payment Option:

Cheque/NEFT/DD Number

Cheque/NEFT/DD Date

Bank

Payment options: Annual Monthly Quarterly Half-yearly

In case of installment payment options i.e. monthly, quarterly and half-yearly, ECS (Auto-debit is must) For Auto-debit facility, you are required to submit Auto-debit authorization form separately.

Card Payment Option : Charge the premium to my Credit Card Debit Card Date of Expiry /

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.

8. 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

Please tick (✓) if you want to opt for Auto Renewal (If yes, please fill the ECS Mandate Form)

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.
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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

ACKNOWLEDGMENT

Proposal No. _____

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 (in line with mode of payment opted by you) 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



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

Insurance is the subject matter of solicitation



Royal Sundaram

General Insurance

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URN: RS/Retail Health/ASP/002 | UIN: RSAHLIP20177V011920



Arogya Sanjeevani Policy, Royal Sundaram General Insurance Co. Limited.

PR21171/DEC21

