SMART CASH PLAN HEALTH PROPOSAL FORM



Proposal No.

							,	OR C)FFIC	EUS	SE O	NLY														
Branch Name:																	Bra	nch (Code	e:						
Intermediary: Agen	су 🗌	Direc	et 🗌	Cor	porate	Agenc	у 🗌 (Other	Interi	media	aries															
Intermediaries Name:_																			Inte	rmed	iary (Code	::			
Proposal Received On:																										
Processed By:				Date	а 📗 🗓	DMM	Υ	YY	Υ		Аррі	roved B	y:						D	ate	D	MM	Ш	YY	Y	Υ
Customer ID:																										
	GU:	IDELI	INES	FOR	СОМР	LETION	N OF T	HE FO	RM (1	ГО ВЕ	FIL	LED BY	PRO	POS	ER/I	REPF	RESE	NT <i>P</i>	TIV	(E)						
ÿ Please answer all t	he que	stions	s fully	/ and	corre	ctly. Th	is prop	osal	will b	e the	bas	is of an	y ins	uran	се р	olicy	tha	t We	ma	y issu	ıe. Y	ou m	nust	discl	ose	all facts
Please answer all the questions fully and correctly. This proposal will be the basis of any insurance policy that We may issue. You must disclose all fact relevant to all persons proposed to be insured that may affect our decision to issue a policy or its price, terms, conditions and exclusions.																										
any material particu	The policy shall become void at our sole discretion, in the event of any untrue or incorrect statement, misrepresentation, non-description or non-disclosure in any material particular in the proposal form/personal statement, declaration and connected documents or any material information having been withheld by the Proposer or any one acting on his behalf.																									
If there is insufficie		_				formation	on whe	ther a	as req	ueste	d or	otherw	ise, p	lease	e atta	ach a	sep	arat	e sh	eet.						
ÿ If you are in any do	ubt, ple	ase s	eek th	ne he	lp of o	ur com	pany re	prese	entativ	e or	your	insuran	ce ac	lviso	r.											
γ If We accept a pro Policy if premium is									•											•	mak	ke an	ıy pa	ymei	nt ur	nder the
γ̈ Please fill up this fo																										
A policyholder or pr declaration on his/h			is a pe	erson	ı with c	disabilit	y and i	equir	es ass	sistan	ce in	n compl	eting	the p	orop	osal [·]	form	n, ma	ıy du	ıly au	thori	ze a ı	repre	esent	ative	e to give
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☐ Mr. ☐ Mrs. ☐ Mis	s 🗌 0	thers_				Gende	er 🗆 N	1ale [Fen	nale [3rd	d Gender														
PAN Number								Aac	lhaar	No.																
Name of the Proposer	First N	lame								Mid	dle Na	ame								Las	t Nan	ne	Ш		\perp	
Permanent Address															ı											
(As per address proof)															_											
	C:t-											Ctata														
	City 											State													1	
Landmark						N	abila*								,					Pinco	ode 					
Telephone Mobile* / / / / / / / / / / / / / / / / / / /																										
Current Address (if different from Permanent Address) Same as permanent address																										
	Sa 	me as	s pern 	nane 	nt addi	ress						1 1			ı		1		ı						ı	1 1
																									1	
	City											State														
Landmark																				Pinco	ode					
Telephone						M	obile*								/ _											
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Date of Birth DDMM/ Y Y Y Marital Status: Married Single Nationality: Indian NRI Foreigner							
Education Qualification							
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)							
*Please provide ABHA number (Ayushman Bharat Health Account number) for all the proposed Insured Persons. In case the ABHA number is not available for any Insured Person, you may request to create an ABHA number by visiting the web link: https://abha.abdm.gov.in/abha/v3/register							
e-IA Number (Electronic Insurance Account Number)							
Would you like to open an Electronic Insurance Account with any Insurance Repository?							
If yes, please furnish the below details.*							
Insurance Repository Name *AccountwillbeopenedwithyourName / DOB / Addressasmentionedinthisproposalform.							
If you already have an Electronic Insurance Account, please share the below details							
Account Number							
Account Name							
Insurance Repository Name							
Please specify if you fall under any of the listed categories. (please tick and give details where ever required) 1							
CKYC Number							
Marital Status Single Married Widow/Widower Divorced							
Nationality Nationality							
Occupation							
Are you an existing Royal Sundaram customer?*							
Existing Policy No.							
Customer ID No.							
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)							
. 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)							
Any other officially valid document (please specify)							

			VERAGE SELECTI					
an details Policy Type:	☐ Individual							
oposed policy term Pol	licyTenure: 🗌 1 Ye	ear 🗌 2 Year	s 🗌 3 Years					
m Insured Silver Pla	ın 🗌 Gold Plan	☐ Platinum	Plan					
otional Benefit Perso	onal Accident							
DETAILS OF PERSONS TO BE COVERED								
		DETAILS	F PERSONS TO BE	ECOVERED				
Name (First, Middle, Last)	Date of birth	Gender Relation propo	on to Profession/trade/ ser occupation	Smart Cash Sum Insured	Plan	Personal Accident Sum Insured	Smart Cash Premium	Personal Accident Premium
	D D M M Y Y							
	D D M M Y Y							
	D D M M Y Y							
	D D M M Y Y							
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						Tot	al Premium	
						Fam	ily Discount	
							(if applicable) al Premium	
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ich nominee would be suffic	cient discharge to the	e company. Nor	minee for all other pe	rsons proposed	d to be in ne Propos	sured shall be ti ser/Representat	ne proposer ive:	
ch nominee would be sufficination can be changed at a	cient discharge to the any time during the te	e company. Nor	ninee for all other per y. Following section to dress and contact tails of Nominee	rsons proposed o be filled by th	d to be in ne Propos	sured shall be ti ser/Representat	ne proposer ive:	himself/herself.
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In c	ase the nominee is a minor then pl	lease provide the name	and address o	f the Appointed	e -						
Name of the Appointee Name and add			s of the Appoi	nip with the	Nominee	Age	Ge Contact Number				
Plea	ase provide Nominee Details for n	nembers opting for a P	ersonal Accid	ent cover							
Sl. No	Name (First, Middle, Last)	Nominee Name		inee Relationship he insured perso		Nom	inee address		Nominee o	ontact details	
1											
2											
3											
4											
5											
6											
	e you or other family members pro										
	iny congenital anomalies or develo ave received any treatment or und				or sus	tained any	accident and / o	or diagn	osed with	any disease / illr	
		io. goo a, oa. go., io	,								
If y	es, give details for each person p	roposed									
Sl. No	Name of the Proposed Person	Nature of illness/d	sease/injury	Date first diagnosed		tment taker taken/surge	n/now being ry done	Nam pract	Name of the attending medica practitioner with phone numbe		
1											
2											
3											
4											
5											
6											
Are	there any additional facts affectin	g the proposed Insuran	ce which shou	ld be disclosed	l to Ins	urers?:		•••••	•••••		
Hav	e you ever suffered from or curren	tly suffering from or unc	ler treatment f	for the following	g?						
	Details		Member 1	Member 2	М	ember 3	Member 4	Ме	mber 5	Member 6	
Hi	gh blood sugar / Diabetes		YES NO	YES NO) D	/ES NO	YES NO	YE	s No	YES NO	
Н	eart Disease		YES NO	YES NO) ,	/ES NO	YES NO	YE	S NO	YES NO	
Bl	ood Pressure (Hypertension) / Stro	oke	YES NO	YES NO) .	YES NO	YES NO	YE	S NO	YES NO	
Cł	nronic Obstructive Pulmonary disea	ase	YES NO	YES NO) .	/ES NO	YES NO	YE	S NO	YES NO	
Ar	ny type of Cancer		YES NO	YES NO) .	/ES NO	YES NO	YE	S NO	YES NO	
	ny type of Arthritis		YES NO	YES NO) ,	/ES NO	YES NO	YE	S NO	YES NO	
Se	eizure disorder/epilepsy		YES NO	YES NO) ,	/ES NO	YES NO	YE	S NO	YES NO	
Ki	dney / Liver problems / Any type of	f Hepatitis	YES NO	YES NO) ,	/ES NO	YES NO	YE	S NO	YES NO	
	h	/			. 1						
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)							·)	YE	S NO		
Tf	Yes, please give the following deta	ils									
11	. 55, produce give the following deta										

GENERAL INFORMATION									
Please confirm if any of the persons to be insured is pregnant (applicable for females only) YES NO FAMILY PHYSICIAN DETAILS									
Family Physicians Name									
Contact Number									
Health/ Hospital Cash/PA	Name of the Person covered	Name of the Company	Policy Number	Period of Insurance	Sum Insured	Claim details, claim amount received or receivable (in `)			
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 untit 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. AUTHORIZATION FOR ELECTRONIC POLICY FULFILLMENT AND SERVICE COMMUNICATIONS (Please read carefully and put a check mark against each before signing)									
			by email						
WhatsApp at 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.									
Date DDMMYYY	Y		ignature of the Propose	er / Representative :					
Place :		N	Name of Proposer :						
DECLARATION									
						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 insurer and that the policy will come into force only after full payment of the premium chargeable. 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. I declare that I consent to the company seeking medical information from any doctor or hospital who/which at any time has attended on the person to be									
4. insured/proposer or from any past or present employer concerning anything which affects the physical or mental health of the person to be insured/proposer and seeking information from any insurer to whom an application for insurance on the person to be insured /proposer has been made for the purpose of underwriting the proposal and/or claim settlement. I authorize the company to share information pertaining to my proposal including the medical records of the insured/proposer for the sole purpose of underwriting the proposal and/or claims settlement and with any Governmental and/or Regulatory authority.									
	5. I declare that the premium amount, corresponding to this proposal, is paid out of the legally declared and assessed sources of my income and not out of proceeds of crime related to any Offence under the Prevention of Money Laundering Act, 2002 and rules framed thereunder. I understand that Roya								
0.	reserves the right to call for documents and information to establish the source of funds, as also the right to reject the said proposal or to terminate the insurance contract unilaterally and/or forfeit the premium amount, if I am found to be named in any recognized sanction list/happen to have violated any								
I confirm that the	e premium has been p	aid by	, w	/ho has an insurable in	terest in my policy a	nd refund, if any, shall be			
processed 7. in my bank accour I am (please tick a	nt. all that are applicable):								
8.	_	□HNI □NRI □P	olitically Exposed Perso	on 🗌 Jeweller 🗌 NG	O 🗌 Film Actor 🗆	Producer Others.			

9. ABHA Declaration (Applicable only if you have shared the ABHA number with Us) - I, hereby declare that I am voluntarily sharing Ayushman Bharat Health Account number (ABHA No) for the proposed Insured Persons, with Royal Sundaram, for the sole purpose of accessing my records of medical history, which wil be used to verify/share relevant information provided herein on confidential basis within its Group and /or third party agencies in connection with the Claims, fo the purpose of facilitating insurance/ reinsurance services and ancillary services. 10. I consent to the fact that Royal Sundaram may download my/proposer's CKYC record from the Central KYC Records Registry, in relation to the verification of my/proposer's KYC records as part of this proposal. I understand that acceptable officially valid documents shall be relied upon for the said verification of KYC records. I, also, consent to receive information from the Central KYC Registry through SMS/email on the above-mentioned mobile phone number/email address. It is, also, confirmed that the KYC records available in the CKYC Registry are current and valid, as on the date of this proposal, and can be used by Royal Sundaram hereafter. In case of any modification, the applicable information will be provided to Royal Sundaram for updating the CKYC Registry Records. 11. I further confirm that I have read and understood the contents of this proposal form, including the terms, conditions, and disclosures provided by the insurer. I have been given an opportunity to seek clarifications, and I am fully aware of the implications of the coverage, premium payments, and policy terms. Date: | D | D | M | M | Y | Y | Y | Y | Signature of the Proposer/Representative : Place: Name of Proposer: __ AUTHORIZATION FOR REPRESENTATIVE (for Persons With Disability Requiring Assistance) I, __ (my relationship to proposer:) to complete this proposal form on my behalf, as I require assistance due to my disability. I confirm that all information provided is accurate and given with my full consent. Contact Number of Authorized Representative: _ Signature of Authorized Representative: Date: DDMMYYYY | **Declaration by Representative** I confirm that I have completed this proposal form on behalf of the proposer to the best of my ability and as per their instructions. Note: The insurer may request identification proof of the authorized representative if required. **VERNACULAR DECLARATION** The terms, conditions, and benefits of the insurance product, its scope of coverage, exclusions, premium details, my rights, obligation and duties was explained to me in my preferred language(dialect) by the persons. Additionally, I was also provided with an opportunity to ask question and seek clarification in my preferred language(dialect) before authenticating this proposal Declarants Name Relationship with proposer Date : DDMMYYYYY | Signature οf the Proposer/Representative: Name Proposer Place: Witness Name: Intermediary / Agent Name: Witness Signature: Intermediary / Agent Signature: POSP Name: POSP Code: POSP PAN No.: Date and Place: **PAYMENT DETAILS**(Please tick (V) payment option) **ASBA Bank Account Details** (For blocking the premium amount under BIMA ASBA facility) ASBA Bank Name IFSC/MICR Code ASBA Bank A/c. No. **Branch Name** ASBA A/c. Holder Name (in case Applicant is different from ASBA A/c. Holder) OR UPI ID (Maximum 45 characters) Type of Account (Savings/Current): 6

ASBA Declaration
I hereby give my consent and authorize Bank to block the
premium amount payable and debit the same from my account under BIMA ASBA facility upon acceptance of my proposal for Insurance by Royal Sundaram General Insurance Company.
If the ASBA bank account is held by a person other than the Proposer, I confirm that I have obtained the consent of the account holder for the blocking and
debiting of the premium amount as per the terms of the BIMA ASBA facility. Signature of the Proposer/Representative:
Signature of the Proposer/Representative: Signature of the Account Holder (if different from Proposer):
Date: D D M M Y Y Y Y
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 :DDMMYYYY 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 INSURANCE

- Sundaram Finance Group -

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



www.royalsundaram.in

SMART CASH PLAN HEALTH PROPOSAL FORM



Proposal No.

ACKNOWLEDGEMENT

Date | D | D | M | M | Y | Y | Y | Y

We acknowledge with thanks the receipt of your insurance proposal. Please note that under	er the ASBA facility, an amount of Rs
has been blocked in the ASBA account on	_ as per the details provided. The mere submission of this proposal or
blocking of funds does not obligate us to issue a policy, which decision is and always shall	be in out sole and absolute discretion. If we accept the proposal, the
premium amount will be debited, and the policy will be issued subject to its terms and con	ditions. We shall have no liability whatsoever if premium is not received
by us in full and in time or is not realized. I we do not accept the proposal, we will inform ye	ou and refund the payment, if any, received from you without interest.
Signature of the receiver and office seal	
ST	

ROYAL SUNDARAM INSURANCE

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