EDELWEISS HEALTH TOP UP INSURANCE - PROPOSAL FORM

Edelweiss | GENERAL INSURANCE

We feel on top of the world, because you thought of us for your health top-up!

Instructions for filling up the form (to be filled by Proposer)

1.Please give complete information about yourself by answering all the questions correctly. If a question is not related to you, just write it is not applicable to you. (All questions are mandatory)

2.We are providing you this Insurance cover with the good intention of serving you sincerely. We hope you have not only given us all the important information related to you but also any other information you think can be of real importance. If there is any such information, please provide it.

3.If we come to know that you have not given correct information and / or have hidden some important fact in this Form, personal statement and / or any other related document, the Policy will be cancelled and your insurance coverage will stop immediately.

4.If you have any doubts and want more information, kindly contact our office nearest to you, or your agent.

5. We request you to use original Proposal Form only because photocopies will not be accepted.

NOTE: The insurance coverage will start only after we accept your Proposal Form and receive the full premium.

Servicing Branch Code: _____ **Servicing Branch Name:** _____

1. Your Intermediary – the only one who can come between us!

Intermediary name: _____ Intermediary reference code: _____

Intermediary Contact: _____ Intermediary Email: _____

Intermediary Sales Person's name: _____ Intermediary Sales Person's contact: _____

Intermediary Sales Person's code: _____ Source code: _____

POS UID Aadhaar No./PAN: _____

2. About the Proposer – the most important person here!

Name:(Mr./Ms./Mrs.): (First Name) (Middle Name) (Last Name) _____

Postal Address: _____

Locality: _____ City: _____

Pin Code: _____ State: _____ Landmark: _____

Permanent Address: (If same as above, please tick here:) _____

Locality: _____ City: _____

Pin Code: _____ State: _____

Telephone: _____ Mobile: _____ Email: _____

Date of Birth: D D M M Y Y Y Y Gender: Male ☐ Female ☐ Third gender ☐ Marital Status: _____

Annual Income: Less than 5 Lac ☐ Between 5-10 Lacs ☐ Between 10-20 lacs ☐ 20 Lacs and above ☐

ID Proof Type: *PAN ☐ Passport ☐ Driving License ☐ EPIC ☐ Form 60 ☐

Nationality: Indian ☐ Other (Pl. Specify): _____ Annual Income: (₹): _____

Occupation: Salaried ☐ Self Employed ☐ Others ☐ Details (if others): _____

Edelweiss Group Employee: Yes ☐ No. ☐ If Yes, please provide the Employee number: _____

3. Policy Details - So what are you looking for in this policy?

Plan: Please select any one: Top Up ☐ Super Top ☐

Sum Insured (In Lacs) (in ₹) _____

For individual type proposal with more than one insured & Different Sum insured pls mention Sum insured in table no.5 below.)

The Sum Insured can be selected from the options mentioned in the Prospectus

Deductible (In Lacs): _____ Deductible options can be selected from the options mentioned in the Prospectus

Proposed Policy Period: D D M M Y Y Y Y To D D M M Y Y Y Y

Policy Term (In Years): 1 ☐ 2 ☐ 3 ☐

Premium Payment Mode: Single ☐ Half Yearly ☐ Quarterly ☐ Monthly ☐

Cover Type: Individual ☐ Floater ☐

Any Existing active Policy with Us (EGIC) (For eg, Motor, Health, Fire Etc): Yes ☐ No ☐ If Yes, Provide the policy number & Customer ID: _____

Any other active policy With Edelweiss Group Entity: Yes ☐ No ☐ If yes Please provide the below details:

1. Policy Number: _____

2. Group Entity Name: _____

3. Product Details: _____

Are you applying for Portability: Yes ☐ No ☐ If Yes, please fill Portability Form, separately and also (Annexure A)

Optional Covers: Want to take Optional Covers too? Good thinking!

Plan Name	Top Up	Super Top Up
	Please select any one option as per the Plan opted above (wherever applicable)	
Pre-existing Disease Waiting Period Waiver/ Reduction	Yes ☐ No ☐ If Yes please select any one option from below 1) 12 months Waiver (Waiting priod applicable would be 24 months) 2) 24 months Waiver (Waiting priod applicable would be 12 months) 3) 36 Months Waiver (No Waiting period)	
Base Policy Co-pay Support • This cover cannot be opted if option Voluntary co-pay is selected •This cover would be applicable in case the Customer has an active base health Insurance Policy with Us or any Health/ General Insurance Company at the time of inception or at the time of renewal of this product	Please select the Sum Insured from the below range: ₹1,000 - ₹50,000 Please select any one option from Below: I have a Base Health Insurance Policy With Edelweiss General Insurance Company Limited or with any Health/General Insurance Company Yes ☐ No ☐	Please select the Sum Insured from the below range: ₹1,000 - ₹2,00,000 Please select any one option from Below: I have a Base Health Insurance Policy With Edelweiss General Insurance Company Limited or with any Health/General Insurance Company Yes ☐ No ☐
Base Policy Higher Room Rent Support Note: This cover would be applicable in case the Customer has an active base health Insurance Policy with Us or any Health/ General Insurance Company at the time of inception or at the time of renewal of this product	Please select the Sum Insured from the below range: ₹1,000 - ₹50,000 Please select any one option from Below: I have a Base Health Insurance Policy With Edelweiss General Insurance Company Limited or with any Health/General Insurance Company. Yes ☐ No ☐	Please select the Sum Insured from the below range: ₹1,000 - ₹2,00,000 Please select any one option from Below: I have a Base Health Insurance Policy With Edelweiss General Insurance Company Limited or with any Health/General Insurance Company. Yes ☐ No ☐
New Born Care	☐ New Born Cover within Maternity (Maternity Sum Insured deductible applicable) Applicable if only maternity is opted) ☐ New Born Cover within Base SI from Day 1 (Base Policy deductible applicable)	
Vaccination Cover	Please select the Sum Insured from the below range: ₹1,000 - ₹50,000	
Double Sum Insured for Critical Illness (CI)	Yes ☐ No ☐	
Assistance services (Domestic and Worldwide)	Yes ☐ No ☐	
Hospital Cash	Yes ☐ No ☐ If yes Please select any one option from each of the below options: 1) Sum Insured Options- a) 500/Day ☐ b) 1,000/day ☐ c) 2,000/day ☐ d) 3,000/day ☐ e) 5,000/day ☐ 2) Number of Days -1 day to 10 days 3) Deductible - 0, 1, 2, 3, 4, 5 days	
Dental OPD Cover	Yes ☐ No ☐ If yes Please mention Sum Insured from the below given range: From ₹1,000 - ₹50,000	
Restoration Benefit	Yes ☐ No ☐	
Recharge Benefit	Yes ☐ No ☐	
Worldwide Coverage (Extended Coverage)	Yes ☐ No ☐ • If this cover is opted, Assistance Services would be by default Worldwide	
Maternity	Yes ☐ No ☐ If yes: Sum Insured – ₹50,000 Please select the deductible from the below Range ₹5,000- ₹25,000	Yes ☐ No ☐ If yes please select any one option from the below each Sum Insured Options: ₹50,000 ☐ ₹75,000 ☐ ₹1,00,000 ☐ ₹150000 ☐ (Maximum Deductible will be 50% of the maternity Sum insured selected by the Customer within the range of ₹5000-₹50,000 But in case if the SI option is ₹150,000, still the customer can select maximum deductible upto ₹50,000.)

Organ Donor	Yes ☐ No ☐ If yes, Please mention the Sum Insured from below given range: 10% of SI to 50% of SI
Emergency Ambulance	Yes ☐ No ☐ If yes Please select any one option for Sum Insured 1) 1500/Event ☐ 2) 2000/Event ☐ 3) 2500/Event ☐ 4) 3000/Event ☐
241 Optional Cover	Yes ☐ No ☐ Can be opted for by the Insured if one year policy term is opted
Voluntary Co-Pay	Yes ☐ No ☐ If Yes Please select any one option 10% ☐ 20% ☐

4. Nominee Details

Nominee Name: _____ Date of Birth: D D M M Y Y Y Y Relationship with Proposer: _____

If the Nominee is of age 18 years or less, kindly fill the details below

Guardian Name: _____ Date of Birth: D D M M Y Y Y Y Relationship With Minor: _____

In case the insured person dies, payment due, if any, will be paid to the person nominated in this Proposal Form.

The receipts of the proceeds by the nominee would count as sufficient discharge by us. The nominee for all the other person(s) who are insured will be the proposer him/herself.

Annexure A - Moving from another insurer? Welcome!

Portability details*

Name of the Previous Insurer	First Policy number	Pre-existing diseases	Expiring Policy Sum Insured (Original sum insured):	Expiring Policy No claim bonus if any	Date of first Inception of Policy

* We reserve the right to modify or amend the terms and the applicability of the Portability benefit according to the regulations and guidance issued by the IRDAI and as amended from time to time.

5. Insured Details - Who are the wonderful people this policy will cover?

Name of Insured	Gender	Date of Birth	Relationship with Policy Holder	Insured Blood Group	Height	Weight	Nationality

Name of Insured	Nominee Name	Relationship With Insured	Nominee's DOB	If Nominee is Minor	
				Guardian Name	Relationship with Insured

Name of Insured	Sum Insured	Fresh / Renewed / Ported	Plan	Deductible	Date of Inception	No-Claim Bonus	Insured with US SINCE	Pre-existing disease

Note: For any additional members, kindly use a separate sheet in the above format.

6. Details of your (very reasonable) premium.

Cheque / Demand Draft no. / Authorisation ID: _____

Payment amount (₹): | | | | | | | | Premium amount (₹): | | | | | | | |

Premium amount in words(Rs.): _____

Date: D D M M Y Y Y Y Bank Name: _____

In case of payment through Cheque/Demand Draft, it should be drawn in favour of "Edelweiss General Insurance Company Limited"

Your Bank Account – in case we need to pay you!

Account Number: | | | | | | | | | | | | | | | | | Account Type : _____

IFSC: | | | | | | | | | | | Bank Name: _____

Branch Name: _____ Name of Account Holder: _____

NOTE: Please submit copy of cancelled cheque along with Proposal Form.

I declare that the information given above is true and correct. I hereby authorise Edelweiss General Insurance Company Limited to directly credit pay-out/refund, if any, to the above mentioned account and I shall not hold Edelweiss General Insurance Company Limited responsible for non-credit/non-payment of pay-out or refund, if any, due to any reason including, but not limited to incorrect/incomplete information. Edelweiss General Insurance Company Limited reserves right to use any alternative pay-out option such as cheque/demand draft in spite of providing above information.

Date: D D M M Y Y Y Y Signature of the Proposer:

Place: _____ (On behalf of all the persons to be insured under the Policy)

7. Medical/Lifestyle Related Information

Are the people to be insured in good health?

Medical/Lifestyle Related Information

Particulars	Insured Person (Yes = Y, No = N)							
	1	2	3	4	5	6	7	8
Does any proposed insured currently or in past diagnosed/suffered/treated/taken medication for any of the following conditions: If yes, please provide details in the additional information section below:								
1. Diabetes								
2. Hypertension/High BP								
3. Epilepsy								
4. High Cholesterol								
5. Thyroid Disorder								
6. Asthma								
7. Kidney Disorder (Stone, Infection, Failure, Polyp)								
8. Cancer								
9. Heart Disease								
10. Liver Diseases (Cirrhosis, Jaundice, Hepatitis)								
11. Is any of the proposed insured, receiving any treatment/medication or have in the past received treatment or undergone surgeries for any medical condition/-disability? (Yes/No)								
12. Please provide details of hereditary medical history, if any:								
13. Does any of person proposed to be insured the proposed insured has have any allergies / reaction to any drug?								
14. *Whether insured / Spouse is pregnant if yes please provide expected delivery date of baby. If expected delivery date of baby falls less than or equal to 9 months from first inception of this optional cover , then please attach copies of antenatal check-up reports /first consultation paper/ USG/ any screening test done.								
15. *If self or spouse is not insured then please provide health status details (If receiving any treatment/medication, or has in the past received treatment or undergone surgeries for any medical condition/disability?)								
*Mandatory question if Newborn Care optional cover option is chosen								

8. Additional information (if your answer is 'yes' to any of the above questions or the proposed to be insured are suffering from any other pre-existing disease which is not mentioned in the above list, please provide details here)

Name of Insured Person	Details of Disease/ Condition

9. Details of Family Doctor

Name of Family Physician: _____ Contact Number: | | | | | | | | | | |

Address: _____

Email ID: _____

10. Details of Previous/Existing Health Insurance

Please fill out the following details with respect to health insurance proposals/policies with us or any other insurance company.

Particulars	Insured Person (Yes = Y, No = N)							
	1	2	3	4	5	6	7	8
Have any of the person(s) to be insured ever filed a claim with their current/previous insurer? If Yes, please provide details on a separate sheet.								
Has any of your proposal(s) for Health insurance been declined, cancelled, charged a higher premium or issued with special condition(s)?								
Is any of the person(s) proposed for insurance covered under any other health insurance policy with the Company?								

11. Statutory Warning

Prohibition of Rebates

(Under Section 41 of Insurance Act 1938)

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 a policy accept any rebate, except such rebate as may be allowed in accordance with the published prospectuses or tables of the Insurer.
2. Any person making default in complying with the provisions of this section shall be liable for a penalty which may extend to ten lakh rupees.

12. Declaration

a. I/We hereby declare, on my behalf and on behalf of all person(s) proposed to be insured, that the above statements, answers and/ or particulars given by me/us are true and complete, in all respects, to the best of my/our knowledge and that I/we am/are authorized to propose on behalf of these other persons .

b. I/We understand that the information provided by me/us 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 .

c. 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..

d. I/We declare that I/We consent to the Company seeking medical information from any doctor or hospital, who/ which , at any time has attended on the person to be 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 which 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.

e. I/We authorize the Company to share information pertaining to my/our proposal including the medical records, of the insured/proposer for the sole purpose of underwriting the proposal and/or claims settlement with any Governmental and/or regulatory authority

Other Important Declarations :

1. I/We agree to receive service related information from Edelweiss General Insurance Co. Ltd. and its service providers from time to time, through electronic and telecom modes, including WhatsApp, and understand that no unsolicited information will be sent to me/us.
2. I/We, hereby, further declare, on my behalf and on behalf of all persons proposed to be insured, that I/We have fully understood the product features, including its suitability, the contents of this proposal form and all other connected documents significant and incidental to availing the insurance policy from the Company

Date: D D M M Y Y Y Y

Place: _____

Signature of proposer/authorized signatory
(On behalf of all the persons to be insured under the policy)

Vernacular Declaration

Certification in case the proposer has signed in vernacular (to be witnessed by someone other than agent/employee of the company).

Name of the Proposer:

The content of this form and its particulars have been explained by me in vernacular to the proposer who has understood and confirmed the same:

Signature of the Proposer

Signature of the witness:

Date: D D M M Y Y Y Y

Name of witness:

Place: _____

Declaration By Insurance Agent/ Intermediary

I, _____, in my capacity as an Insurance Agent/ POSP/ Specified Person of the Corporate Agent/ authorised person of the Broker/ IMF, do hereby declare that I have explained the product features, including its suitability, and 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 response(s) submitted by the Proposer, in this Proposal Form, to the questions contained herein and that any details sought herein shall form the basis of the contract of insurance between the Company and the Proposer, if this Proposal is accepted by the Company. I have further explained that if any untrue statement(s)/ information/ response(s) is/ are contained in this Proposal Form, including addendum(s), affidavit(s), statement(s), submission(s), or if there has been a non-disclosure of any material fact, the policy issued thereon shall, at the option of the Company, be treated as null and void and the premium amount paid against the policy may be forfeited by the Company.

Name of Insurance Agent/ POSP/ Specified Person of the Corporate Agent/ authorised person of the Broker/ IMF: _____

Agency Code/ License No.: _____

Date: D D M M Y Y Y Y

Place: _____

As a go-green initiative, Edelweiss General Insurance Co. Ltd. shall be sending the policy documents to your e-mail address, as provided by you in this Proposal Form.

☐ I do not want the physical copy of my policy documents.

☐ I want the physical copy of the policy documents to be sent to my address, as mentioned in this Proposal Form.

ACKNOWLEDGEMENT

Thanks for your proposal dated_____for health insurance of_____and _____persons.

We're grateful for the premium you sent us, by way of cash/ cheque/ demand draft/ others, vide instrument no._____,

for an amount of ₹_____.

Please note that neither the submission of a completed proposal for insurance to us nor any payment, obliges us to agree to issue a policy, such a decision is and always shall be at our sole and absolute discretion.

If we accept the proposal, it shall be subject to the policy terms and conditions and we shall have no liability to make any payment if the appropriate premium amount is not received by us in full and in time, or is not realised or the requirement for pre-policy check-up is not fulfilled.

If we do not accept the proposal, we will inform you within 15 days from the date of receipt of this proposal and refund any payment received from you without interest

Signature of the receiver and official seal