

# PROPOSAL FORM - GROUP HEALTH INSURANCE

## FOR OFFICE USE ONLY

Branch Name	_____	Branch Code	<input type="text"/>
Intermediary Name	_____	Intermediary Code	<input type="text"/>
Proposal Received On	<input type="text"/>	RM Name	_____

## GUIDELINES FOR COMPLETION OF THE FORM (TO BE FILLED BY PROPOSER)

Please answer all the questions fully and correctly, please mention clearly that the same is not applicable. This proposal will be the basis of any insurance policy that we may issue. You must disclose all facts relevant to all persons proposed to be insured that may affect our decision to issue a policy or its price, terms, conditions and exclusions. 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 insufficient space for you to provide information whether as requested or otherwise, please attach a separate sheet. If you are in any doubt, please seek the help of our company representative or your insurance advisor. If we accept a proposal for insurance, it shall be subject to the Policy terms and conditions and we shall have no liability to make any payment under the Policy if premium is not received by Us in full and in time, or is not realized or proposal is not accepted by Us.

All fields/details marked with \* are mandatory.

## PROPOSER DETAILS

Please fill up this form in CAPITAL LETTERS

Proposer Name*	<input type="text"/>											
Proposer's trade or business	<input type="text"/>	Business Sector	<input type="checkbox"/> Urban	<input type="checkbox"/> Rural								
Type of Proposer	<input type="checkbox"/> Individual	<input type="checkbox"/> Partnership firm	<input type="checkbox"/> Company	<input type="checkbox"/> Government	<input type="checkbox"/> Other (Please specify _____)							
Annual Income (in INR)	<input type="text"/>	Paid up capital of firm (in INR millions)	<input type="text"/>									
PAN Number*	<input type="text"/>	GST number	<input type="text"/>									
Do you file Income tax return? Yes <input type="checkbox"/> No <input type="checkbox"/>	Do you have a bank account? Yes <input type="checkbox"/> No <input type="checkbox"/>											
Address for Correspondence*	<input type="text"/>											
	City:	<input type="text"/>	State:	<input type="text"/>								
	Pin Code:	<input type="text"/>	Landline:	<input type="text"/>								
Mobile No.*	<input type="text"/>	<input type="text"/>										
E Mail ID	<input type="text"/>											

## CONTACT PERSON DETAILS\*

Contact Person's Name*	<input type="text"/>											
Address for Correspondence*	<input type="text"/>											
	City:	<input type="text"/>	State:	<input type="text"/>								
	Pin Code:	<input type="text"/>	Landline:	<input type="text"/>								
Mobile No.*	<input type="text"/>	<input type="text"/>										
E Mail ID	<input type="text"/>											

## RISK DETAILS

**Scope of Cover:** This Policy covers hospitalization expenses incurred for diseases contracted or injuries sustained in India. Medical expenses up to 30 days for Pre-hospitalization and up to 60 days for post-hospitalization are also admissible. The sum insured under this Policy for a particular Insured person and/or all the dependent members of his/her family shall be as set out in the Policy.

**Major exclusions:** Pre Existing Diseases, Diseases contracted During First 30 Days, Cost of Spectacles / Contact Lenses, Dental Treatment, AIDS, Pregnancy and certain specified diseases during first year of the Policy. For a detailed set of exclusions, kindly refer the policy document.

**Add ons:** In addition certain optional extensions are available, the details of which, are provided in the relevant section of this proposal form.

**Note:** Please add sheets if space is insufficient.

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Period of Insurance From           To

Total No. of Persons covered

Base Covers opted (Choose one or more)	<input type="checkbox"/> Inpatient Care	<input type="checkbox"/> Hospital Cash	<input type="checkbox"/> Out-patient Cover
Optional Extension Covers	<input type="checkbox"/> Pre-existing cover <input type="checkbox"/> Pre & Post Hospitalization expenses <input type="checkbox"/> Domiciliary Cover <input type="checkbox"/> Maternity Cover	<input type="checkbox"/> Ambulance Cover <input type="checkbox"/> AYUSH treatment <input type="checkbox"/> Health Check-up <input type="checkbox"/> Other (Please specify) _____	
If you want to avail exclusion of coverage under the policy with consequent reduction of premium, please specify	<input type="checkbox"/> Room rent capping <input type="checkbox"/> Room category limit <input type="checkbox"/> Accidental Hospitalization cover <input type="checkbox"/> Other (Please specify) _____		
Do all the members proposed to be insured form part of One Group or Association or Corporate body? Yes <input type="checkbox"/> No <input type="checkbox"/>			

Please provide list of persons to be insured in following format.

Name	Relationship with employee/Self	Date of Birth	Age (in years)	Gender	Sum Insured	Existing disease, if any

Please note: Name of dependents should be mentioned immediately below the name of each employee.

## PREVIOUS POLICY & CLAIMS DETAILS

Period of Insurance		Name of Insurer	Policy Number	Cover Details	Total Premium (INR)	Total Amount of claims (Paid+ outstanding)
From	To					
<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>					
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### Important Notes:

- The information that you give to us on this proposal form or in any supplementary information form or documentation supplied by you or on your behalf will influence our decision to offer insurance and the terms upon which to offer it. Further, any policy we issue will be based on what you have communicated to us. It is therefore important that your answers are complete and accurate in all respect.
- The questions in this proposal are indicative rather than exhaustive. You must provide us with all information relevant to the risk to be insured, even if it is not the subject of a question in this proposal. If you are in any doubt as to what information should be given, you should liaise with your insurance advisor/ company.
- Acceptance of your proposal would be subject to realization of full premium amount by the company.
- The list of exclusions/ inclusions and other policy details are indicative, for complete list and comprehensive details kindly refer policy wordings.



# PROPOSAL FORM - GROUP HEALTH INSURANCE

## NEFT/EFT MANDATE FORM

### Client details

Client Name																															
Address																															
City:																State:															
Pin Code:						Landline:																									
PAN Card No.																															
Pan card holder's name																															

### Account details:

Bank Name																														
Account Number																														
Branch Name																														
Payee Name																														
Account no.																														
Account type																														
Name as per Bank records																														
IFSC Code																														
Cancelled Cheque copy:- Y/N*																														

**(Please attach a blank cancelled cheque copy with payee name printed on the cheque and Pan Card Copy)**

If customer name/ account no /IFSC code is not available on cancelled Cheque then NEFT mandate form with Bank Sign & seal and customer signature is mandatory.

I hereby declare that the particulars given above are correct and complete. If the transaction is delayed or not effected at all reasons of incomplete or incorrect information, I would not hold the user institution responsible.

Sign and stamp of the payee

Verified by  
(Bank Official Stamp and Authorized Signature)

### Terms and Conditions for Payments through RTGS/NEFT

- The details provided by the Customers in the Mandate Form shall be considered as final and Magma HDI General Insurance Company Limited shall not be responsible for cross verification of any of the details provided therein.
- The RTGS/ NEFT facility shall be effective for the respective Customer(s) within 15 days of the receipt of the Mandate Form by Magma HDI General Insurance Company Limited and/ or within such period as may be reasonably required by Magma HDI General Insurance Company Limited to activate the RTGS/ NEFT facility.
- The Customer agrees that under the RTGS/ NEFT facility, there may be a risk of non-payment in the Account of Customer on the day of the credit of Payments due to change in the applicable regulations pertaining to RTGS/ NEFT facility or due to any other reasons without any fault/inaction/failure on part Magma HDI General Insurance Company Limited or any factor beyond the control of Magma HDI General Insurance Company Limited.
- The Customer agrees to indemnify, without delay or demur, Magma HDI General Insurance Company Limited and its agents and keep Magma HDI General Insurance Company Limited and its agent indemnified harmless at all times from and against any and all claims, damages, losses, costs, and expenses (including attorney's fees) which Magma HDI General Insurance Company Limited may suffer or incur, directly or indirectly, arising from or in connection with, amongst other things, either of the aforesaid reasons stated in above clauses.
- The Customer agrees that transaction(s) through RTGS/ NEFT facility may attract inward RTGS/ NEFT charges, which if levied by the Customer's bank, shall be borne by the Customer.
- Magma HDI General Insurance Company Limited has the absolute discretion to amend or supplement any Terms and Conditions stated herein at any time and will endeavor to give prior notice of Ten days for such changes wherever feasible for the terms and conditions to be applicable. By using the new services, or at the completion of such period, whichever is earlier, the Customer shall be deemed to have accepted the changed terms and conditions.
- Submission of documents or bank details or any other information does not in any way, shape or form, imply or express or suggest admission of liability by the company.
- Notices under these terms and conditions may be given in writing by delivering them by hand or e-mail or on Magma HDI General Insurance Company Limited website www.magmahdi.com or by sending them by post to the last address of the Customer.
- These terms and conditions will be governed by the laws of India and any legal action or proceedings arising out of these Terms and Conditions shall be initiated in the courts or tribunals at Mumbai in India.
- I/ We further undertake to refund any excess amount whether demanded by Magma HDI General Insurance Company Limited or not, which has been credited in excess to my account at any time due to any reason within 7 days of such receipt of such communication from Magma HDI General Insurance Company Limited of such excess credit or such information of excess credit coming to the knowledge of the Customer through any other source.
- I/ We agree that my/our claim payment will be credited from the date Magma HDI General Insurance Company Limited gets confirmation from its bankers, This facility will continue unless it is revoked by any party and any issuance of relevant credit instruction from Magma HDI General Insurance Company Limited to its bankers will be valid till such instruction is complete irrespective of the fact that the notice period has expired provided such a credit request has been made by Magma HDI General Insurance Company Limited before the expiry of the notice period of the Customer.
- (Please attach a blank cancelled cheque or photocopy of a cheque for verification of the particulars provided in this regard)

Signature and stamp of customer \_\_\_\_\_