ACKO GROUP HEALTH OPD WALLET

PROPOSAL FORM

NOTE: This form is to be completed by the Group/ Association/ Institution/ Corporate Body. We are under no obligation to accept any proposal for insurance. The liability of the Company does not commence until this proposal is accepted by the Company and premium is received in full.

Please ensure that the information in this form material for assumption of risk is true, accurate and complete in all respects as inaccuracy or non-disclosure of the requested information or other material facts could preclude recovery of any claim under the policy.

Please complete this form in CAPITAL LETTERS. The proposal form is to be submitted in original, copies shall not be accepted.

FOR OFFICE USE

Branch Name: _____ **Branch Code:** _____
Intermediary Name: _____ **Intermediary Code:** _____
Business Type: _____ **Channel Type:** _____
Proposal Form No.: _____ **Intermediary Contact:** _____

I. PROPOSER (GROUP) DETAILS:

All invoices will be raised to the following address and addressed to the principal contact person specified below.

Proposed Policy Period From: DD/MM/YYYY To: DD/MM/YYYY

- Proposer Name: _____
- Description of the Proposer's Business: _____
- Principal Contact Person Name: _____
- Correspondence Address: _____
  City: _____State: _____ Pin Code: _____
- Telephone Number: Mobile: _____ Office (*Optional*): _____
  E-mail: ID 1 _____ ID 2 _____
- Pan No. / TAN No.: _____ (*Mandatory for premium of INR 50,000 and above if accepted in Cash/Demand Draft, or INR 100,000 and above by Cheque/Credit Card/Debit Card*)
- Customer Goods & Service Tax Identification Number (*if any*): _____
- Mode of Payment: _____
- Frequency of Payment: Monthly / Quarterly / Half Yearly / Yearly

- Nature of Group: Employer/employee OR Non-employer/employee
- Description of the Group to be insured: _____

- Nature of Policy: Named basis OR Unnamed basis
- Please state whether all eligible Insured Persons/families of the Group / Association / Institution / Corporate Body are proposed for insurance? _____

II. DETAILS OF PREVIOUS INSURER(S) (IF RENEWAL):

- Are your employees/ Insured Persons at present insured under any Group Health Insurance Policy?
  Yes ___ No ___ (*If 'Yes' Please provide the details insurer, type of policy with coverage & sum insured - attach additional sheet if required*)

- Name of Insurer: _____
- Policy Number: _____
- Expiring terms of cover: _____
- Period of insurance: _____
- Premium paid: _____
- Claim details: (*Please attach separate sheet providing complete details of claims with individual claim records*)
- Incurred Claims Ratio: _____

III. DETAILS OF INSURED PERSONS

Note: *1. This list will be attached to and forming part of the proposal form and policy to be issued.*
2. Separate list should be attached in respect of persons proposed to be covered under each Sum Insured.
3. All nominations will be in accordance with Section 39 of the Insurance Act 1938.
4. A Minor should not be declared as nominee.

Coverage Category	No. of Employees	No of Members
Category A*		
Category B*		
Total		

A and B might be defined within a group, depending on the seniority, nature of work etc.

For Named member / Employees: Fill the Annexure 1
For Unnamed member / Employees:

Please attach additional sheets, if space not sufficient to complete details.

IV. BENEFITS:

Category	Basis of Coverage (Individual/Floater)	Floater Unit (in case of Floater)	Selected Benefits
Category A			Refer Annexure II.A
Category B			Refer Annexure II.B

Note: *All the benefits can be chosen for the category. Please select the benefits that you wish to avail* as per Annexure 2

V. DECLARATION & AUTHORISATION

1. I 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 am authorised 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.

3. 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.

4. 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 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.

5. I authorize the company to share information pertaining to my proposal including the incident details, loss or inconvenience caused to the insured, 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.

I submit that the foregoing information is true to the best of my knowledge, and accept that if found to be untrue in any form, the Company reserves the right to alter/ cancel the coverage available under this Policy.
Note: The liability of the Company does not commence until full premium has been realized by the Company and the acceptance of the proposal has been formally intimated to the insured.

Principle Contact Person Name: _____

Date: _____ Signature of the Proposer: _____

Place: _____

VI. SALES PERSON/INSURANCE AGENT/INTERMEDIARY DECLARATION

I, _____(Full Name) in my capacity as an insurance Agent/ Specified Person of the Corporate Agent/authorized employee of the Broker or authorized Sales Person of the Company, 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 response(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 further more 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 premiums paid under the Policy may be forfeited to the Company.

License No. / ID (*Agent / Corporate Agent / Broker / Sales Person*): _____

Date: _____ Signature of Proposer/ Intermediary: _____
Place: _____

VII. PROHIBITION OF REBATES (SECTION 41 OF INSURANCE ACT, 1938, AS AMENDED)

1. No person shall allow or offer to allow, either directly or indirectly, as an inducement to any person to take out 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 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 prospectus or tables of the insurers.

2. Any person making default in complying with the provisions of this section shall be liable for penalty which may extend to 10 lakh rupees.

Annexure *1:

Sr No	Name of Insured Person	Unique Employee No/Customer Relationship number	Relationship of family with primary Insured	Date of Enrolment/ Joining	Age	Gender	Nominee Name & Relationship with Insured Person	Mobile No.	Email ID	Address of the Insured
1.										
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Note: *This list is indicative and details could be modified according to the Nature of Group/ Policy.

Annexure 2:

Please provide details pertaining to sum insured or conditions opted for each benefit and enter "None" for Cover Benefits not opted for.

Benefits selected for Category <Name>

Sr No.	Name of the Benefit	Event Covered (Illness/Injury)	Sum Insured/Sub-limit	Other Conditions (please specify)
1	Online Consultation			
2	Physical Consultation			
3	Prescribed Diagnostic Tests			
4	Prescribed Pharmacy			
5	Preventive Health Check-up			Test(s) details: _____
6	Outpatient Treatment			
7	Vaccination			Vaccination details: ____
8	Outpatient Dental Treatment			
	a) Emergency Dental Services benefit			
	b) Preventive Dental Services			
	c) Dental Radiology Benefit			
	d) OPD Dental Consultation			
	e) Conservative Benefits (Filings)			
	f) Extraction Benefits (non-surgical)			
	g) Endodontic Benefit (Root Canal Treatment)			
9	Eye Care			
	a) Eye Care Consultation			
	b) Eye Care (change in eye power)			
	c) Eye Care OPD			
10	Medical Equipment Cover			
11	Limit of Reimbursement			Reimbursement limit: ___
	Cover Options			
1	Additional Buffer Sum Insured for the Group			
2	Group Deductible			Deductible: Rs_____

Waiting Period

Sr No.	Waiting Periods	Selected Period
1	Pre-Existing Disease Waiting Period	

Special Conditions (if any):

1.
2.

Declarations (if any):

1.
2.

Annexure **3:

Please provide details pertaining to the Health Wallet deduction mechanism for all claims arising under this Policy for the opted benefits

Schedule of Cost for Category <Name>

Sr No.	Name of the Benefit	Sum Insured	Per claim deduction	Other Conditions
1	Online Consultation		General Practitioner: Rs_____ Specialist: Rs _____	
2	Physical Consultation		General Practitioner: Rs _____ Specialist: Rs _____	
3	Prescribed Diagnostic Tests		As per test grid opted	
4	Prescribed Pharmacy		Actuals / MRP	
5	Preventive Health Check-up		As per test grid opted	
6	Outpatient Treatment		As per treatment availed	
7	Vaccination		As per vaccination opted	
8	Outpatient Dental Treatment			
	a) Emergency Dental Services benefit		Actuals (on medical expenses)	
	b) Preventive Dental Services		Actuals (on medical expenses)	
	c) Dental Radiology Benefit		Actuals (on medical expenses)	
	d) OPD Dental Consultation		Fixed, Rs: _____	
	e) Conservative Benefits (Filings)		Actuals (on medical expenses)	
	f) Extraction Benefits (non-surgical)		Actuals (on medical expenses)	
	g) Endodontic Benefit (Root Canal Treatment)		Actuals (on medical expenses)	
9	Eye Care			
	a) Eye Care Consultation		Fixed, Rs: _____	
	b) Eye Care (change in eye power)		Fixed, Rs: _____	
	c) Eye Care OPD		Fixed, Rs: _____	
10	Medical Equipment Cover		Fixed, Rs: _____	
11	Limit of Reimbursement			
	Cover Options			
1	Additional Buffer Sum Insured for the Group			
2	Group Deductible			

Note: **This list is indicative and details could be modified according to plan opted by the Group