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## Kotak Accident Care - Premium Plan PROPOSAL FORM

KACP

### GUIDELINES FOR COMPLETION OF THE PROPOSAL FORM

1. Please fill the proposal form in BLOCK LETTERS. All details with \* are mandatory.
2. The issuance of this form by Kotak Mahindra General Insurance Company Limited (hereafter referred as "Company") does not amount to acceptance of the proposal. The actual liability of the Company does not commence until this proposal has been accepted by the Company through the issuance of the Policy Document and the premium has been realized in full.
3. This proposal will be the basis of any subsequent Policy that the Company issues to you. It is therefore essential that you provide all the information in this proposal FULLY, AND ACCURATELY AND CORRECTLY in respect of person proposed to be insured and that you provide us with any and all additional information relevant to risk to be insured or our decision as to acceptance of the risk or the terms upon which it should be accepted.
4. Please note that all questions left unanswered or blank will be considered to be answered as "Not Applicable"
5. If you require additional space to answer any question on this Proposal Form, please attach additional sheets of paper and indicate on the additional sheet the question number to which the information being provided pertains.

### FOR OFFICE USE ONLY

| Quote No.* | Quote Date* | Branch Code | Sales Manager Code | Intermediary Code | Intermediary Service RM | Intermediary Branch Code | Intermediary Business Vertical | Intermediary Client Ref. No. | SP Name/Code | PoS Person PAN /Aadhar No. |
|------------|-------------|-------------|--------------------|-------------------|-------------------------|--------------------------|--------------------------------|------------------------------|--------------|----------------------------|
|            |             |             |                    |                   |                         |                          |                                |                              |              |                            |

### PROPOSAL DETAILS

Policy Period\*     1 Year     2 Years     3 Years

Proposed Policy Period\*    From  To

### SECTION I

### PROPOSER DETAILS

Title    Mr. / Miss. / Mrs.   

Name\*   

First Name
Middle Name
Last Name

Gender\*     Male     Female     Others    Date of Birth\*        Risk Category   

Nationality        Marital Status     Single     Married     Others

Permanent Address\*

Address (Line 1)   

Address (Line 2)   

Nearest Landmark        City / District   

State        Pin Code        Country   

Is Correspondence Address same as Permanent Address?\*     Yes     No    If 'No', please provide below

Address (Line 1)   

Address (Line 2)   

Nearest Landmark        City / District   

State        Pin Code        Country   

Phone        Mobile\*   

Emergency Contact No.        Email\*   

Occupation     Business     Salaried     Professional     Student     Housewife     Retired     Others

Professional Qualification\*     CA     Paramilitary Services     Govt. Teacher     Govt. Employee     Medical Doctor     Others

PAN        GSTIN   

Kotak Group Employees     Yes     No    If yes, Employee ID        Any existing policy from Us     Yes     No    If yes, Policy No.   

Correct communication details will enable us to deliver the policy certificate & contact you

## SECTION II

## COVERS AVAILABLE UNDER THE POLICY

You can opt for the following Covers / Extensions. Please write Yes or No as required.

| Section                    | Covers  | Yes / No | Sum Insured (₹) |
|----------------------------|---|----------|-----------------|
| Section A                  | Death Resulting from Accident                               |          |                 |
|                            | Permanent Total Disablement (PTD) resulting from Accident   |          |                 |
|                            | Permanent Partial Disablement (PPD) resulting from Accident |          |                 |
| Extensions under Section A | Carriage of Dead Body                                       |          |                 |
|                            | Children's Education Grant                                  |          |                 |
|                            | Ambulance Charges   |          |                 |
| Section B                  | Accidental Hospital Daily Cash Benefit                      |          |                 |
|                            | Accidental Hospitalization Expenses Reimbursement           |          |                 |
|                            | Convalescence Benefit                                       |          |                 |

For selection of covers under the said Plan, please refer to the Plan Details in the Prospectus.

## SECTION III

## INSURED INFORMATION

| Insured Person Details   |   |
|--|---|
| Name in Full*  |   |
| Relation with the Proposer*  |   |
| Date of Birth DD/MM/YYYY*  | __/__/__  |
| Gender*  | <input type="checkbox"/> M <input type="checkbox"/> F |
| Occupation*  |   |
| Annual Income (₹)*   |   |
| Marital Status*  |   |
| Nominee Name (Nominee for the Proposed Insured Persons other than the Policy Holder under the policy will be the Policy Holder)* |   |
| Relationship of Nominee with Insured*  |   |

## SECTION IV

## OTHER INSURANCE DETAILS

Please provide the details of similar policies held by the persons to be insured with us and with other Insurers

| Sr. No. | Name in Full | Policy No. | Insurer | Policy Sum Insured | Policy Start Date |
|---------|--------------|------------|---------|--------------------|-------------------|
|         |              |            |         |                    |                   |
|         |              |            |         |                    |                   |
|         |              |            |         |                    |                   |

Kindly provide the particulars of the losses for the past 3 years period for which policy availed.

1. Name & Address of the Insurer

Policy Period From  To  Policy Number

Total Premium (₹)  Nature of loss

Total Amount of claims (₹)

2. Name & Address of the Insurer

Policy Period From  To  Policy Number

Total Premium (₹)  Nature of loss

Total Amount of claims (₹)

3. Name & Address of the Insurer

Policy Period From  To  Policy Number

Total Premium (₹)  Nature of loss

Total Amount of claims (₹)

4. Name & Address of the Insurer

Policy Period From  To  Policy Number

Total Premium (₹)  Nature of loss

Total Amount of claims (₹)

Any additional information relevant to the policy applied for

**\*PAYMENT DETAILS**
 **Cheque**    **Demand Draft (DD)**    **Credit/Debit Card**    **Online Payment**   (In favour of Kotak Mahindra General Insurance Company Limited)

Cheque / DD#  Amount  Drawn On  Date

Bank  Branch  IFSC/MICR Code

For Credit/Debit Card: Transaction Reference No.  Transaction Date

**BANK ACCOUNT DETAILS**

Mandatory details required to process all payment due in relation to your policy including refunds (if any) and / or claims directly to your bank account. Please select any one of the below options as applicable.

Bank details as per premium cheque to be used for electronic fund transfer.    No existing Bank Account#    Cancelled Cheque submitted of Other Bank

# I agree to open a bank account and provide my bank account details to the Company for electronic fund transfer as mode of payment. I shall provide these details before renewal of my insurance policy or before any payment becomes due in relation to my insurance policy (whichever is earlier). I understand that as per regulatory requirement, Company shall process any payment in relation to my insurance policy only through electronic fund transfer after receipt of aforesaid pending bank details from me.

**Particulars of Bank Account:**

Bank Name  Account Holder Name

Account No.  IFSC/MICR Code

**Disclaimer:** Kotak Mahindra General Insurance Company Limited shall not be liable to anybody, in any manner, whatsoever if the NEFT transaction does not complete

Date\*

\*Signature

Sample

**ACKNOWLEDGEMENT**

Received from Ms./Mrs./ Mr

a sum of ₹  through Cheque/DD  against your proposal for Kotak Accident Care Policy.

Signature of Kotak Mahindra General Insurance Limited Official / Intermediary  Date

Kotak Mahindra General Insurance Company Limited Official / Intermediary Name

Time   Place

**Note:** Neither the submission of a completed proposal for insurance or any payment for any policy sought oblige the Company to agree to issue a policy, which decision is and always shall be in the Company's sole and absolute discretion. If Kotak Mahindra General Insurance Company Limited accepts a proposal for insurance, it shall be subject to the Board approved underwriting policy of Kotak Mahindra General Insurance Company Limited and the policy Terms and Conditions of Kotak Accident Care Insurance Policy and the Company shall have no liability to make any payment if premium is not received by Kotak Mahindra General Insurance Company Limited in full and in time, or is not realised. If a proposal is not accepted, Kotak Mahindra General Insurance Company Limited will inform you and refund any payment received from you without interest. **Insurance is a subject matter of solicitation**

**ELECTRONIC INSURANCE ACCOUNT DETAILS OF PROPOSER (E-MAIL ID IS MANDATORY)**

|   |   |
|---|---|
| Do you have an EIA Account  | <input type="checkbox"/> Yes <input type="checkbox"/> No  |
| If Yes, please quote EIA Number   |   |
| Please mention name of Insurance Repository   |   |
| If No, do you want Us to create an EIA account for you  | <input type="checkbox"/> Yes <input type="checkbox"/> No (If Yes, please fill up Insurance Repository Application form) |
| Email id (Registered with Insurance Repository)   |   |
| Your address details as mentioned in the EIA account shall override the address provided in this application for Insurance. |   |

**DECLARATION**

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 authorized to propose on behalf of these other persons.

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 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.

Place\* Date\* 

Signature/Thumb impression of Proposer\*

**VERNACULAR DECLARATION**

I hereby declare that, I have fully explained the contents of the proposal form and terms and conditions of the Policy to the Proposer in the language understood to him/her and that the Proposer has affixed the thumb impression / signature after fully understanding the contents thereof.

Signature/Thumb impression of Proposer

Place\* Date\* 

Signature of Intermediary/ Sales Person\*

**DECLARATION FOR AGENT**

I hereby declare that, I have fully explained the features and terms & condition of the policy in detail to the Proposer and the Proposer has affixed the thumb impression / signature after fully understanding the features thereof.

Signature/Thumb impression of Proposer

Place\* Date\* 

Signature &amp; Stamp as applicable of the Insurance Advisor/Specified person of Corporate Agent/Authorised Employee of Broker/Sales person\*

**STATUTORY WARNING****PROHIBITION OF REBATES (Under Section 41 of Insurance Act 1938 as amended)**

- 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.
- Any person making default in complying with the provisions of this section shall be punishable with fine, which may extend to Ten Lakhs Rupees.