

## Kotak Group Accident Care PROPOSAL FORM

KGAE

v2

**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

**SECTION I**

**PROPOSER DETAILS**

Proposer Name\*

First Name
Middle Name
Last Name

Permanent Address\*  
 Address (Line 1)   
 Address (Line 2)   
 Nearest Landmark  City / District   
 State  Pin Code  Country

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

Address (Line 1)   
 Address (Line 2)   
 Nearest Landmark  City / District   
 State  Pin Code  Country

Principal Contact Person's Name

Type of Business  Email ID

Contact No.  Period of Insurance From  To

PAN^  Aadhaar No^  GSTIN

Please state whether all eligible Employees/families, Members/ families of the Group/Association /Institution/Corporate Body are proposed for Insurance?  Yes  No

Please state the Total Number of Employees/ Members to be covered (including families/ dependents wherever covered):

Any existing policy from us?  Yes  No If Yes, Policy No

(^) Please provide for the Authorised signatory also.

**SECTION II**

**INSURED DETAILS (AS PART OF ANNEXURE TO PROPOSAL FORM)**

Please provide details of Insured Persons (If persons proposed to be covered under the group more than the specified rows, please attach a separate sheet giving full details as per below mentioned table)

Member No./ Employee No.*	Name of Insured*	Relationship with Employee / Member*	Date of Enrolment /Joining*	Occupation*	Income (per annum)*	Date of Birth*	Gender*	Email ID	Mobile No.	Sum Insured	Nominee & their Relationship with Insured/ Appointee in case Nominee is Minor


In the event of the death of the Proposer any payment due under the Policy shall become payable to the nominee in accordance with the Policy terms and conditions. Nominee for any of the persons proposed to be insured shall be the Proposer. The nominee must be an immediate relative of the Proposer. The nominee for all other Insured Persons proposed to be insured shall be the Proposer himself/herself.

### SECTION III

#### COVERAGES

	Covers	Opted for Yes / No	Sum Insured (₹)
<b>Section A Benefits</b>	Accidental Death		
	Permanent Total Disablement		
	Permanent Partial Disablement		
	Temporary Total Disablement		
<b>Extensions to Section A</b>	Ambulance Charges		
	Modification Allowance		
	Out-patient Treatment Cover		
	Children's Education Grant		
	Funeral Expenses Extension		
	Marriage Benefit for Children		
	Disappearance Benefit		
	Compassionate Visit		
	Sports Activity Cover		
	Carriage of Dead Body		
<b>Section B</b>	Funeral Expenses		
	Accidental Hospital Daily Cash Benefit		
	Convalescence Benefit		
	Burns Benefit		
	Broken Bones Benefit		
	Coma Benefit		
	Accidental Hospitalisation		
	Domestic travel for medical treatment		
Loss of Job due to Accident			

\* Mandatory cover - Any one cover either from section A or B

#### ASSIGNMENT DETAILS (IF ANY)

Bank / Institution Name	<input type="text"/>		
Loan Account Number	<input type="text"/>	Loan Amount	<input type="text"/>
Loan Tenure	<input type="text"/>	EMI Amount	<input type="text"/>
		Loan Sanction Date	<input type="text"/>

### SECTION IV

#### PAST POLICY CLAIMS DETAILS

Name of Insurer	
Policy Number	
Expiring Terms of cover	
Period of Insurance	
No. of lives Insured	
Premium paid	
Claim details (Last 3 years)	(Please attach separate sheet providing complete details of claims)
Incurred Claims Ratio	

## SECTION V

## PREMIUM PAYMENT DETAILS

Payment Frequency	<input type="checkbox"/> Monthly <input type="checkbox"/> Annual	Payment Mode	<input type="checkbox"/> DD <input type="checkbox"/> Cheque
Premium Amount	<input type="text"/>	Instrument No.	<input type="text"/>
Premium Amount (in words):	<input type="text"/>		
Bank Name	<input type="text"/>		

For cheque/ DD (Payable in favour of "Kotak Mahindra General Insurance Company Limited)

For installment premium policies, the revival period shall be 15 days. Wherever premiums are not received within the revival period the policy will be terminated and all claims that fall beyond such installment due date shall not be covered as part of the policy. However, We will be liable to pay in respect of all claims where the treatment/admission/accident has commenced/occurred before date of termination of such policies.

## SECTION VI

## 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\*

## AADHAAR DECLARATION

I hereby provide my consent in accordance with Aadhar Act, 2016, Prevention of Money Laundering Act, 2002, Prevention of Money Laundering (Maintenance of Records) Rules and the applicable norms for the following:

- To validate/authenticate my Aadhar number with UIDAI
- To collect, store, share and use the details provided above in accordance with the applicable norms

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 of Intermediary/ 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.

**Kotak Mahindra General Insurance Company Ltd.**

CIN: U66000MH2014PLC260291. Registered Office: 27 BKC, C 27, G Block, Bandra Kurla Complex, Bandra East, Mumbai – 400051. Maharashtra, India.

Office: 8th Floor, Zone IV, Kotak Infinity, Bldg. 21, Infinity IT Park, Off WEH, Gen. AK Vaidya Marg, Dindoshi, Malad (E), Mumbai – 400097. India.

Toll Free: 1800 266 4545 Email: care@kotak.com Website: www.kotakgeneralinsurance.com IRDAI Reg. No. 152.