

KOTAK GROUP SMART CASH

For any assistance please call 1800 266 4545 or
visit www.kotakgeneralinsurance.com

KGSC

v1

PROPOSAL FORM

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 Liability of the Company in relation to the subject matter of this Proposal does not commence until this Proposal has been accepted by the Company through the issuance of the Policy Document/Cover Note and subject to the receipt by the Company of the premium paid.
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, ACCURATELY AND CORRECTLY in respect of all persons proposed to be insured and that you provide the Company with any and all additional information relevant to risk to be insured or the Company's decision as to acceptance of the risk or the terms upon which it should be accepted.
4. The Policy shall become voidable at the option of the Company, in the event of any untrue or incorrect or incomplete 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 proposed policyholder or any one acting on its behalf to obtain any benefit under this Policy.
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. (Information given herein will be treated in strict confidence).

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

PROPOSER'S INFORMATION

Name of the Proposer/ Group Administrator (Organisation/ Institute/ Association)*

Proposer's Trade/ Business/ Activity *

Proposer's Postal Address

City / District Pin code State Country

GSTIN

Contact No Email ID

PAN^ Aadhaar No.^

Any existing policy from Us Yes No If 'Yes', Policy No

Are you a Non-profit Organization? Yes No

(^) Please Provide for the Authorised signatory also.

COVERAGE DETAILS (*)

1. Policy Period: From: To: Midnight of

2. Policy Category: Individual/ Family Floater

3. Number of Persons to be insured

Categories of proposed Insured (Add more categories if needed) – (senior management, middle management, management trainee, etc.)	
a. Cat 1:	<input style="width: 90%;" type="text"/>
b. Cat 2:	<input style="width: 90%;" type="text"/>
c. Cat 3:	<input style="width: 90%;" type="text"/>
d. Cat 4:	<input style="width: 90%;" type="text"/>
e. Cat 5:	<input style="width: 90%;" type="text"/>

4. Family Definition:

5. Relationships Covered:

6. Type of Credit (#)

7. Installment Option* Yes No If yes, Installment Frequency*: Monthly Quarterly Half yearly

BENEFIT DETAILS (*)

(#) Applicable only to credit linked policies

Please Tick on the Benefit You want to opt for

Sr. No.	Benefits under the Policy	Tick on Cover You want to opt	Sum Insured/Daily Cash Amount	Maximum No. of Days	Deductible / Franchise / Remarks
Base Covers					
1.	Hospital Daily Cash Benefit	<input type="checkbox"/> Yes <input type="checkbox"/> No	₹ _____ per day	_____ days	Deductible <input type="checkbox"/> _____ days or Franchise <input type="checkbox"/> _____ days
2.	Accident Daily Cash Benefit	<input type="checkbox"/> Yes <input type="checkbox"/> No	₹ _____ per day	_____ days	
3.	ICU Daily Cash Benefit	<input type="checkbox"/> Yes <input type="checkbox"/> No	₹ _____ per day	_____ days	

Optional Covers					
1.	Convalescence Benefit	<input type="checkbox"/> Yes	<input type="checkbox"/> No	₹ _____	
2.	Companion Benefit	<input type="checkbox"/> Yes	<input type="checkbox"/> No	₹ _____ per day	_____ days
3.	Joint Hospitalisation	<input type="checkbox"/> Yes	<input type="checkbox"/> No	₹ _____	
4.	Parent Accommodation	<input type="checkbox"/> Yes	<input type="checkbox"/> No	₹ _____ per day	_____ days
5.	Day Care Procedure Benefit	<input type="checkbox"/> Yes	<input type="checkbox"/> No	₹ _____	
6.	Surgery Benefit	<input type="checkbox"/> Yes	<input type="checkbox"/> No	₹ _____	
7.	Accidental Hospitalisation Benefit	<input type="checkbox"/> Yes	<input type="checkbox"/> No	₹ _____	
8.	Broken Bones	<input type="checkbox"/> Yes	<input type="checkbox"/> No	₹ _____	
9.	Burns	<input type="checkbox"/> Yes	<input type="checkbox"/> No	₹ _____	
10.	Maternity Benefit	<input type="checkbox"/> Yes	<input type="checkbox"/> No	₹ _____ per day	_____ days
11.	New Born Baby Benefit	<input type="checkbox"/> Yes	<input type="checkbox"/> No	₹ _____ per day	_____ days
12.	Alternative Treatment Benefit	<input type="checkbox"/> Yes	<input type="checkbox"/> No	₹ _____ per day	_____ days
13.	Worldwide Cover	<input type="checkbox"/> Yes	<input type="checkbox"/> No	₹ _____ per day	_____ days
14.	Personal Accident Benefit	<input type="checkbox"/> Yes	<input type="checkbox"/> No	₹ _____	
15.	Critical Illness Benefit	<input type="checkbox"/> Yes	<input type="checkbox"/> No	₹ _____	
16.	Pre-existing Disease Waiting Period Waiver	<input type="checkbox"/> Yes	<input type="checkbox"/> No	NA	
17.	30 days Waiting Period Waiver	<input type="checkbox"/> Yes	<input type="checkbox"/> No	NA	
18.	First Year Waiting Period Waiver	<input type="checkbox"/> Yes	<input type="checkbox"/> No	NA	
19.	Maternity Benefit Waiting Period Waiver	<input type="checkbox"/> Yes	<input type="checkbox"/> No	NA	

INSURED DETAILS (*All fields are mandatory)

Membership ID/Employee Number/ Account Number pertaining to Credit (#)	Name of the Financier (#)	Credit Tenure (#)	Name of the Insured Person	Category	Applicant/ Co-applicant (#)	Date of Birth DD/MM/YYYY	Gender	Credit sanctioned date (#)	Credit Amount/ outstanding credit amount (#)	Relationship with the Insured Person	Designation/ Occupation	Any existing illness	Nominee Details			
													Name	Relationship with the Insured Person	Date of Birth DD/MM/YYYY	Appointee Details in case Nominee is a Minor

(#) Applicable only to credit linked policies

PREVIOUS POLICY DETAILS

Kindly provide the particulars for the past 3 policy periods or lesser period for which policy availed, in the following format.

Policy Period From – To	Name of the Insurer	Policy number	Number of members covered	Total premium (₹)	Total amount of claims (Paid + Outstanding) (₹)

*PAYMENT DETAILS:

Cheque Demand Draft (DD) Credit/Debit Card Online Payment

Cheque / DD# Amount
Date Bank
Branch (In favour of Kotak Mahindra General Insurance Company Ltd.)
IFSC/MICR Code

For Credit/Debit Card

Transaction Reference No Transaction Date

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 signature after fully understanding the features thereof.

Signature/Thumb impression of Proposer

Place* Date*

Signature of Intermediary/ Sales Person*

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 and Stamp of Proposer

AADHAAR DECLARATION

I hereby provide my consent in accordance with Aadhaar Act, 2016, Prevention of Money Laundering Act, 2002, Prevention of Money Laundering (Maintenance of Records) as amended from time to time and the applicable regulations for the following:

- i. To validate/authenticate my Aadhaar number with UIDAI
- ii. To collect, store, share and use the details provided above in accordance with the applicable regulations.

Place* Date*

*Signature and Stamp of Proposer

STATUTORY WARNING**PROHIBITION OF REBATES (Under 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 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 punishable with fine, which may extend to Ten Lakhs Rupees.

Sample

ACKNOWLEDGEMENT:

Received from Ms./Mrs./ Mr.

sum of ₹ Through Cheque/DD against your proposal for Kotak Group Smart Cash.

Signature of Kotak Mahindra General Insurance Company 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 Group Smart Cash 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 within 15 days from the date of receipt of the proposal.

Kotak Mahindra General Insurance Company Ltd.

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. CIN: U66000MH2014PLC260291. IRDAI Reg. No. 152.