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Kotak Health Care - Prime
PROPOSAL FORM

KHCR

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 thisproposal FULLY, AND ACCURATELY AND CORRECTLY in respect of all persons 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

Type of Cover* ☐ Individual ☐ Family Floater

Policy Period* ☐ 1 Year ☐ 2 Years ☐ 3 Years

Base Annual Sum Insured (₹)* ____

Proposed Start Date* DD/MM/YYYY

Sample

SECTION I

PROPOSER'S INFORMATION

Title Mr. / Miss. / Mrs. ____

Name* First Name ____ Middle Name ____ Last Name ____

Gender* ☐ Male ☐ Female ☐ Others Date of Birth* DD/MM/YYYY

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* ____

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

Occupation* ☐ Business ☐ Salaried ☐ Professional ☐ Student ☐ Housewife ☐ Retired ☐ Others

Profession* ☐ 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. ____

SECTION II

INSURED INFORMATION

Any one or more of the following can be covered - Proposer, Proposer's spouse, dependent children, dependent parents.

	Proposed Insured Person 1	Proposed Insured Person 2	Proposed Insured Person 3	Proposed Insured Person 4	Proposed Insured Person 5	Proposed Insured Person 6
Name in Full*						
Relation with the Proposer*						
Date of Birth DD/MM/YYYY*	___/___/_____	___/___/_____	___/___/_____	___/___/_____	___/___/_____	___/___/_____
Gender*	☐ M ☐ F	☐ M ☐ F	☐ M ☐ F	☐ M ☐ F	☐ M ☐ F	☐ M ☐ F
Height (in cm)*						
Weight (in kg)*						
Occupation* (Dependent children who are unmarried and unemployed upto age of 25 years can be covered)						
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						
Any pre- existing disease*						
Date/Year when illness was first detected DD/MM/YYYY*						
Treatment(s) taken for the illness along with duration for which the treatment(s) medication was taken.						
Any Hospitalisation for the illness/ailment? If yes give the duration of Hospitalisation. If any surgery done for the illness give the name of the surgery						
Was the illness / ailment completely cured or not?						
What is the current medication for the illness?						
In case of any history of Hospitalisation please name the ailment and period of Hospitalisation						

*please provide details of 10 years I Note: Please provide an additional sheet if space is not sufficient to complete details.

Sample

SECTION III

ADDITIONAL COVERS/ EXTENSIONS

Sr. No.	Basic Cover	
(i)	In-patient Treatment	Upto opted Base Annual Sum Insured
(ii)	Day Care Treatment	150 listed Day care procedures
(iii)	Pre-Hospitalisation Medical Expenses	Upto 30 days
(iv)	Post-Hospitalisation Medical Expenses	Upto 60 days
(v)	Ambulance Cover	₹1500/-
(vi)	Free Health Check-up	for each Insured Person above 18 years of Age, each Policy Year
(vii)	Cumulative Bonus	10% of the opted Base Annual Sum Insured for each claim free year, upto a maximum of 50%

You can opt for the following optional extension packs on payment of additional premium. Please write Yes or No as required. Details of the extension packs are as per Prime Plan;

Sr. No.	Extensions	Yes / No
(i)	Hospital Daily Cash	
(ii)	Convalescence Benefit	
(iii)	Domiciliary Hospitalisation cover	
(iv)	Donor Expenses	
(v)	Alternative treatment	
(vi)	Critical Illness Cover	
(vii)	Maternity benefit	
(viii)	New Born Baby Cover	
(ix)	Compassionate Visit	
(x)	Restoration of Sum Insured	
(xi)	Double Sum Insured for Hospitalization due to Accident	

SECTION IV

EXISTING HEALTH INSURANCE POLICIES

	Proposed Insured Person 1	Proposed Insured Person 2	Proposed Insured Person 3	Proposed Insured Person 4	Proposed Insured Person 5	Proposed Insured Person 6
Type of Policy						
Period of Insurance						
Insurance Company						
Base Annual Sum Insured						

INSURED INFORMATION

1. Have You or any person proposed to be insured under the Policy suffered from any medical conditions or disabilities or health problems, or have been Hospitalized have had any surgical operation be it be intermittent, recurring or otherwise. If yes, please give full details below. If space is insufficient, please continue on a separate sheet of paper. Refer to the list below.

Sr. No.	Symptoms/Disorders	Proposed Insured Person 1	Proposed Insured Person 2	Proposed Insured Person 3	Proposed Insured Person 4	Proposed Insured Person 5	Proposed Insured Person 6
(i)	Smoke/consume tobacco						
(ii)	Infections						
(iii)	HIV/AIDs						
(iv)	Cancer/Tumor						
(v)	Nutritional/Endocrinal disorders/Diabetes						
(vi)	Mental Psychiatric Disorders						
(vii)	Nervous System Disorders						
(viii)	Disorders of the Eyes/Ears/Nose/Throat						
(ix)	Disorders of the Circulatory System/Heart Disease/hypertension						
(x)	Respiratory Infections and Diseases, Asthma						
(xi)	Diseases of Stomach, Intestines, liver, appendix						
(xii)	Bones and Joints, Spondylitis/Arthritis etc.						
(xiii)	Kidney and urinary system						
(xiv)	Pregnant/Gynaecological Disorders/Prostrate						
(xv)	Birth Defects						
(xvi)	Any other disease or surgery or accidents/burns						

2. Details of the Pre-existing Conditions/ Diseases (please provide details for past ten years)

	Name	Pre-existing Illness/Conditions	Date	Duration	Cured/ Undergoing treatment
Proposed Insured Person 1					
Proposed Insured Person 2					
Proposed Insured Person 3					
Proposed Insured Person 4					
Proposed Insured Person 5					
Proposed Insured Person 6					

3. Have You or any person proposed to be insured under the Policy has ever been refused insurance cover by an insurance company or been accepted on special terms? YES I No

If yes, please give full details:

Sample

*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 DD MM YYYY

Bank ______ Branch ______ IFSC/MICR Code ______

For Credit/Debit Card: Transaction Reference No. ______ Transaction Date DD MM YYYY

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

ACKNOWLEDGEMENT:

Received from Ms./Mrs./ Mr. ______

a sum of ₹ ______ Through Cheque / DD ______ against your proposal for Kotak Health Care Policy.

Signature of Kotak Mahindra General Insurance Company Limited Official / Intermediary ______ Date DD / MM / YYYY

Kotak Mahindra General Insurance Company Limited Official/Intermediary Name: ______

Time H H M M 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 Health 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	☐ Yes ☐ 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	☐ Yes ☐ 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 & 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)

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.

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