v3

Kotak Health Super Top Up
Proposal Form (Classic)

KSPC

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 on non-disclosure in any material particular in the Proposal Form /personal statement, declaration and connected documents, or any material information having been with held 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

PROPOSAL DETAIL

Type of cover: ☐ Individual ☐ Family Floater Plan Name* Classic

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

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

Proposed Start Date*

Section I

PROPOSER'S INFORMATION

Title Mr. / Miss / Mrs. / M/s / Others

Name*

First Name Middle Name Last Name

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

Nationality Marital Status Single ☐ Married ☐ Others ☐

Contact No. Email id :

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

Correspondence Address*

Address (Line 1)

Address (Line 2)

Nearest Landmark City / District State Pin Code

Country Email*

Phone Mobile* Emergency contact No.*

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

Profession* ☐ CA ☐ Paramilitary Services ☐ Govt. Teacher ☐ Govt. Employee ☐ Medical Doctor ☐ Others

PAN GSTIN

Are you an existing customer of Kotak Mahindra Bank Ltd. / Kotak Mahindra Prime Ltd.? If Yes, CRN

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

Section II

BASIC COVERAGE /DETAILS:

Sr. No.	Basic Covers	Cover Details
(i)	In-patient Treatment	Upto opted Base Annual Sum Insured
(ii)	Day Care Treatment	405 listed Day care procedures
(iii)	Pre-Hospitalization Medical Expenses	Upto 30 days
(iv)	Post-Hospitalization Medical Expenses	Upto 60 days
(v)	Ambulance Cover	₹ 2000/- per event.
(vi)	Organ Donor Cover	Upto opted Base Annual Sum Insured
(vii)	Alternative Treatment	up to ₹ 50,000/- (subject to availability of opted Base Annual Sum Insured)
(viii)	Restoration of Sum Insured	Upto opted Base Annual Sum Insured
(ix)	Double Sum Insured for Hospitalization due to Accident	- Double of opted Base Annual Sum Insured - Only up to ₹ 40 Lakhs
(x)	Cumulative Bonus	- 10% of the Sum Insured for each claim free year, upto a maximum of 50%

For Pre-existing disease, waiting period of 48 months is applicable.

Please refer to below table and specify the Deductible and Sum Insured

Deductible (₹)	Sum Insured (₹)		
2 lakhs	☐ 3 lakhs	☐ 5 lakhs	☐ 8 lakhs

Section III

INSURED INFORMATION

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

Insured Details

Name in Full*	Relation with the Proposer*	Date of Birth DD/MM/YYYY*	Gender*	Height (in cm)*	Weight (in kg)*	Occupation*	Marital Status*

Nominee Details	Insured 1	Insured 2	Insured 3	Insured 4	Insured 5	Insured 6
Nominee Name*						
Relationship of Nominee with Insured*						
Nominee Date of Birth DD/MM/YYYY*						

	Insured 1	Insured 2	Insured 3	Insured 4	Insured 5	Insured 6
Section A: Medical and Hospitalisation						
Information Details of hospitalization for the illness / ailment / Medicine / Test / Surgery						
Are you currently in good mental and physical health – Yes/No						
Are you currently suffering or previously suffered from any illness and on continuous medication for same-yes/no (If Yes, Please provide documents for same)						
Name the medication and duration since on treatment						
Diabetes Mellitus If Yes provide duration, type I or II and name of medication						
High BP, Cholesterol If Yes since when and medication being taken						
Have you undergone any medical test or health check–up in the past 6 month if yes then please mention if any abnormal result detected						
Any hospitalization in the past – Yes / No (If Yes, Please provide documents for same)						
Period of hospitalization						
Have You or any of the person proposed to be insured ever suffered from / are suffering from any of the following: Please tick 'YES" for insured wherever applicable						
Infections / Allergies						
HIV / AIDs						
Cancer / Tumor / Cyst						
Nutritional / Endocrinal disorders / Diabetes						
Mental psychiatric Disorders						
Nervous system Disorders						

Disorders of the Eyes / Ears / Nose / throat/						
Disorders of the circulatory system / Heart Disease/ hypertension						
Respiratory Infections and Diseases, Asthma						
Bones and Joints, Spondylitis / arthritis etc.						
Diseases of Stomach, Intestines, liver, appendix						
Kidney and urinary system						
Pregnant / Gynaecological Disorders / any disorder of Prostrate						
Birth Defects						
Accidents / burns						
If any accident in past please give details:						
Year of Accident						
Accident resulting in to deformity or disability hampering mobility						
Section B: Lifestyle Information						
Have You or any of the person proposed has any of the following Habit?						
Smoking / Tobacco consumption - Yes / No						
If Yes, Duration and Quantity per day						
Alcohol consumption - Yes / No						
If Yes, Duration and Quantity						
Section C: Existing Health Insurance Details						
Type of Policy						
Period of Insurance						
Insurance Company						
Base Annual Sum Insured (₹)						
Section D: Details of claims						
Ailment for which claim was made						
Claim amount paid / rejected						
Year of claim						
Others						
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 / No)						
If yes, please give full detail						
Any Pre-existing diseases*						

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

Section IV

*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 Super Top Up policy.

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 Health Super Top Up 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.

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.

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 Infiniti, 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.