

I/ We hereby give my/ our consent to the Company to verify and obtain my/ our identity/ address proof as well as the identity/ address proof of the insured through Central KYC Registry or UIDAI or through any other permitted modes for the purpose of undertaking applicable KYC.

RISK DETAILS

Note: Please add sheets if space is insufficient

Period of Insurance:	<input type="checkbox"/> 1 Years <input type="checkbox"/> 2 Years <input type="checkbox"/> 3 Years <input type="checkbox"/> 4 Years <input type="checkbox"/> 5 Years
Total No. of Persons covered	
Sum Insured Basis	<input type="checkbox"/> Equal to original Amount. <input type="checkbox"/> Can be less than original Amount <input type="checkbox"/> Can be More than original Amount
Base Covers opted. (Choose one or more)	<input type="checkbox"/> Critical Illness <input type="checkbox"/> Infectious Diseases <input type="checkbox"/> Personal Accident <input type="checkbox"/> EMI <input type="checkbox"/> Hospicash <input type="checkbox"/> Loss of Job <input type="checkbox"/> Fire and Allied Perils Dwelling & Household content <input type="checkbox"/> Business Interruption
Optional Extension Covers (Critical Illness)	<input type="checkbox"/> Survival Period <30 days/ Not Applicable>
Optional Extension Covers (Personal Accident)	<input type="checkbox"/> Permanent Partial Disablement (PPD) Cover <input type="checkbox"/> Funeral Cover <input type="checkbox"/> Emergency Road Ambulance Cover <input type="checkbox"/> Double Benefit <input type="checkbox"/> Education benefit
Optional Extension Covers (EMI Cover)	<input type="checkbox"/> Maternity EMI Cover
Optional Extension Covers (Hospital Cash)	<input type="checkbox"/> Maternity Hospital Cash
Optional Extension Covers (Personal Accident)	<input type="checkbox"/> Cover for Valuable Contents on Agreed Value Basis (under Home Contents cover) <input type="checkbox"/> Personal Accident
Do all the members proposed to be insured form part of One Group or Association or Corporate body?	<input type="checkbox"/> Yes <input type="checkbox"/> No

ASSIGNMENT

Will Customer's policy be assigned to Master Policyholder?

Yes No

Ayushman Bharat Health Account

I/We hereby give my/our consent to the Company to verify and obtain my/our medical records through ABHA Yes No

If YES, please indicate the ABHA No. _____

Please create your ABHA No: <https://fasttrack.magmainsurance.com/abha/index>

NOMINEE DETAILS

Name of insured	Name of Nominee	Relationship with insured	% of Nomination	Mobile No	Email ID	Present address	Permanent address	Date of Birth	Bank Details of Nominee						
									Account Holder(s) Name (As appearing in the Bank Records)	Bank Name	Bank Branch Name	Address	Branch City	Account Type	IFSC Code

Do you wish to receive a physical copy of the policy? Yes No

AUTHORIZATION FOR ELECTRONIC POLICY FULFILLMENT AND SERVICE COMMUNICATIONS

(Please read carefully and put a check mark against each before signing)

I hereby consent that the policy documents may be sent to me by email at _____

(Please provide us your e-mail id) or via sms at my mobile no. provided above".

I hereby consent to and authorize Magma General Insurance Limited ("Company") to make welcome calls, service calls or any other communication (electronic or otherwise) with respect to the proposed or existing policy of Company from time to time and subject to the provisions of applicable law.

I wish to get all policy related communications on My WhatsApp number

Whatsapp Number: _____

Date: D D M M Y Y Y Y

Signature of the Proposer: _____

Place: _____

Name of Proposer: _____

VERNACULAR DECLARATION

I hereby declare that I have fully explained the contents of the proposal form and all other documents incidental to availing the health insurance from Magma General Insurance Limited to the proposer in the language understood by him/her. The same have been fully understood by him/her and the replies have been recorded as per the information provided by the proposer. Replies have been read out to, fully understood and confirmed by the proposer.

Declarants Name _____ Relationship with proposer _____

Signature of declarant: _____ Signature of applicant in vernacular: _____

Date: D D M M Y Y Y Y

INTERMEDIARY DECLARATION

I, _____ (Full Name) in my capacity as an Insurance Advisor/ Specified Person of the Corporate Agent/ Authorized employee of the Broker/ Relationship Officer, do hereby declare that I have explained all the contents of this Proposal Form, including the nature of the questions contained in this Proposal Form to the proposer including statement(s), information and responses(s) submitted by him/her in this Proposal Form to questions contained herein or any details sought herein will form the basis of the Contract of Insurance between the Company and the Proposer, if this Proposal is accepted by the Company for issuance of the Policy. I have further explained that if any untrue statement(s)/ information/ response(s) is/ are contained in this Proposal Form / including addendum(s), affidavits, statements, submissions, furnished/ to be furnished, or if there has been a non-disclosure of any material fact, the Policy issued to his/her favour pursuant to this Proposal may be treated by the Company as null and void and all premium paid under the Policy may be forfeited to the Company.

License No./ID (Advisor/Corporate Agent/Broker/Relationship Officer): _____

Date: D D M M Y Y Y Y

Signature of the Insurance Advisor: _____

I [name of proposer] confirm that I have understood all the features/benefits available under this Policy.

Date: D D M M Y Y Y Y

Signature of the Proposer: _____

PROPOSER DECLARATION

(Certification where for any reason, the proposal and other connected papers are not filled in by the Proposer).

The contents of the proposal form and connected documents have been fully explained to me and I have fully understood the significance of the proposed contract. The Proposal Form is filled by _____ under my instruction, and I found it to be correct.

Date: D D M M Y Y Y Y

Signature of the Proposer: _____

FULL ASSIGNMENT

From the policy start date, any claim payable by the company under this policy shall be deposited directly in the loan account number _____ maintained by Financial Institution _____. In the event of any claims becoming payable under this policy, an amount to the extent of Sum Insured, as on the date of claim being incurred, shall be deposited by the company in the aforementioned Loan Account shall be considered as paid to the Insured Person or nominee of the Insured Person or Legal Heir.

Upon the receipt of such amount in the aforementioned manner by the Financial Institution and / or Insured Person, the Insured Person and the financial institution shall completely discharge the company from all liability under the policy and shall be binding on the undersigned and the heirs, executors, administrators, successors or legal representatives of the Insured Person as the case may be.

Date:

Signature of the Proposer: _____

AML GUIDELINES

1. I/we hereby confirm that all premiums paid / payable in future are from bonafide sources and not paid out of proceeds of crime and that such premiums are not disproportionate to my/our income. I / we understand that the Company has the right to call for documents to establish sources of funds and to cancel the insurance policy in case I / we are found guilty by any competent court of law under any of the statutes, directly or indirectly governing the prevention of money laundering law in India.

Date:

Signature of the Proposer: _____

Are you or any of the proposal applicants PEPs* or a close relative/associate of PEPs*? Yes No

If yes, please share the details of "Politically Exposed Persons" (PEPs):

* (PEPs) are individuals who have been entrusted with prominent public functions by a foreign country, including the heads of States or Governments, senior politicians, senior government or judicial or military officers, senior executives of state-owned corporations and important political party officials

2. Additional Information:

Nationality: Indian Non-Indian If, Non-Indian, please specify Country: _____

3. Type of Organisation: (Applicable where an organisation is the proposer. In case of proposer being Individual, Sole Proprietor or HUF, please select option X)

(i) Corporations (ii) Trust (iii) Government (iv) Partnership / LLP (v) Non-Government Organisations
 (vi) Co-operatives (vii) Society (viii) Private Limited Company (ix) Public Limited Company (x) others, please specify _____

4. Source of Funds for premium payment:

Business: _____ Salaried: _____ Others (please specify) _____

DISABILITY DECLARATION

I hereby declare that I have fully explained the contents of the proposal form and all other documents incidental to availing the health insurance from Magma General Insurance Limited. The same have been fully understood by me and the replies have been recorded as per the information provided by him/her. Replies have been explained, fully understood and confirmed by me.

Name _____

Signature _____ Date: _____



SECTION 41 OF THE INSURANCE ACT, 1938 - PROHIBITION OF REBATES

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 continuing the policy accept any rebate except such rebate as may be allowed in accordance with the published prospectus or tables of the Insurer.
2. If any person fails to comply with sub-regulation (1) above, he shall be liable to payment of a fine which may extend to Ten Lakh Rupees.

**Acknowledgment (For office use only)**

Proposal No. _____

Date: DD MM YY YY

We acknowledge with thanks the receipt of your proposal and amount by Cash/Cheque/NEFT/Demand Draft/ Others _____
of amount of Rs. _____ dated _____ drawn on _____.

Neither the submission to us of a completed proposal for Insurance nor any payment for any policy sought obliges us to agree to issue a policy, which decision is and always shall be in our sole and absolute discretion. If we accept a proposal for Insurance, it shall be subject to the policy terms and conditions and we shall have no liability whatsoever if premium is not received by us in full and in time or is not realized.

Signature of the receiver and office seal

