MAGMA General Insurance Limited

Proposal No: _____

1. FOR OFFICE USE ONLY
For Policies sourced through Branch

Branch Name (Intermediary)*		Branch Code (Intermediary)*	
Branch/Office Mobile Number (Intermediary)*		Branch/Office Email Address (Intermediary)*	
Intermediary Name*		Intermediary Code*	
Name of SP/ BQP/ POSP/ Designated Person/ Authorized Verifier/Authorized Salesperson*		Functional identity/Unique ID of SP/BQP/POSP/Designated Person/Authorized Verifier/ Authorized salesperson*	
Sales channel Type		If POSP then please provide the below:-* a) PAN of POSP b) AADHAAR Number of POSP	
For Policies Sourced Digitally			
Principal Officer Name*		Principal Officer – Mobile/ Telephone Number*	
Principal Officer Email Address*			
Proposal Received On			

GUIDELINES FOR COMPLETION OF THE FORM (TO BE FILLED BY PROPOSER)

Please answer all the questions fully and correctly. This proposal will be the basis of any insurance policy that We may issue. You must disclose all facts relevant to all persons proposed to be insured that may affect Our decision to issue a policy or its price, terms, conditions and exclusions. The policy shall become void at Our sole discretion, in the event of any untrue or incorrect 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 Proposer or any one acting on his behalf.

If there is insufficient space for you to provide information whether as requested or otherwise, please attach a separate sheet. If you are in any doubt, please seek the help of Our company representative or your insurance advisor. If We accept a proposal for insurance, it shall be subject to the Policy terms and conditions and We shall have no liability to make any payment under the Policy if premium is not received by Us in full and in time, or is not realized or non-fulfillment of pre-policy medical check-up or proposal is not accepted by Us.

All fields/details marked with * are mandatory.

2. PROPOSER DETAILS

Please fill up this form in CAPITAL LETTERS for yourself and each proposed insured person

Proposer/Policyholder Name * (Mr./Ms./Mrs./Other)	(First Name)	(Middle Name)	(Last Name)
Marital Status:	☐ Single	☐ Married	
Gender:	☐ Male	☐ Female	☐ Third Gender
Nationality*:		Date of Birth* D D M M Y Y Y Y	
Occupation:	☐ Salaried ☐ Self-employed ☐ Professional ☐ Others (please specify) _____		
Educational Qualification:			
Annual Income (in Rs.):	☐ < 3,00,000 ☐ 3,00,000 – 10,00,000 ☐ 10,00,001 – 25,00,000 ☐ >25,00,000		

Address for Correspondence*			
	City:	Gram Panchayat Name:	
	Landmark:	State:	Pin Code:
Phone No.:	STD Code:	Landline No.:	Mobile No.*
GST Number:	_____ (NA if not provided)		
E Mail ID:			
Permanent Address:			
	City:	Landmark:	
	State:	Pin Code:	
Phone No.:	STD Code:	Landline No.:	Mobile No.*
Are you a Magma General Insurance Limited Employee? If yes, Employee ID: _____	Do you have any other Policy with Magma General Insurance Limited ☐ Yes ☐ No		
Residential Status:	☐ Resident Individual ☐ Non-Resident Indian ☐ Foreign National ☐ Person of Indian Origin		
In case you are person having any disability, please provide the below details which will enable us to provide necessary accessible services to you. Type of Disability Percentage of Disability			
PAN*/Form 97		Passport No.:	
Voter ID:		Driving License No.:	
Aadhaar Number		CKYC No.:	

Please share ID proof, address proof, and latest photograph for KYC purpose. PAN is mandatory. Documents required for individuals with foreign nationality, Non-Resident Indians (NRIs), and Persons of Indian Origin (PIOs) are any one from (a) Passport b) Driving License c) Voter Identity Card) along with Letters issued by the Foreign Embassy or Mission in India and relevant identification documents issued by their respective countries.

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.

☐ Yes ☐ No

3. PLAN DETAILS*

Policy Type	☐ Individual ☐ Family Floater ☐ Family Individual	**Policy Period:**	☐ 1 Year ☐ 2 Year ☐ 3 Year ☐ 4 Year ☐ 5 Year
If Family Floater*, number of persons to be covered: Adults: _____ Children: _____		**Premium Payment Frequency**	☐ Single Premium ☐ Monthly Instalment ☐ Quarterly Instalment ☐ Semi-annual Instalment
Zone Opted			

For Multi Individual, please fill in the Annexure for optional Cover

Sum Insured (in Lakh)	☐ 3L ☐ 4L ☐ 5L ☐ 7.5L ☐ 10L ☐ 15L ☐ 20L ☐ 25L ☐ 30L ☐ 50L ☐ 1 Cr ☐ 2 Cr ☐ 3 Cr ☐ Unlimited				
Aggregate Deductible option	☐ Yes ☐ No (if yes, please choose deductible option from below as per SI chosen)				
	Plan SI	**Aggregate Deductible**			
	5L 7.5L 10L, 15L, 20L, 25L 30L, 50L 1 Cr and above	☐ 25L ☐ 50K ☐ 1L ☐ 2L ☐ 3L ☐ 4L ☐ 5L ☐ 25L ☐ 50K ☐ 1L ☐ 2L ☐ 3L ☐ 4L ☐ 5L ☐ 25L ☐ 50K ☐ 1L ☐ 2L ☐ 3L ☐ 4L ☐ 5L ☐ 10L ☐ 25L ☐ 50K ☐ 1L ☐ 2L ☐ 3L ☐ 4L ☐ 5L ☐ 10L ☐ 25L ☐ 50K ☐ 1L ☐ 2L ☐ 3L ☐ 4L ☐ 5L ☐ 10L ☐ 15L			
Voluntary Co-Payment	☐ Yes ☐ No (if yes, please choose option from below) ☐ 10% ☐ 20%		**Hospital Cash (in INR)**	☐ 500 ☐ 1000 ☐ 1500	
Maternity benefit Sum Insureds	☐ Option A ☐ 1,00,000 ☐ 2,00,000 ☐ Option B ☐ 1,00,000 ☐ 2,00,000	**Home treatment additional daily cash (If Yes, INR 1,000 per day)**	☐ Yes ☐ No	**Non-payable expense Cover**	☐ Yes ☐ No
Smart Flexi Saver (Available only if Aggregate Deductible option chosen)	☐ Yes ☐ No	**Air Ambulance Cover**	☐ Yes ☐ No	**Removal of Mandatory Co Pay**	☐ Yes ☐ No
Outpatient Cover	☐ 10,000 ☐ 20,000	**Switch on switch off**	☐ Yes ☐ No	**Global Cover**	☐ Yes ☐ No
Enhanced sublimits for Cataract	☐ INR 1,00,000 per eye per year ☐ 20% sum Insured increase every year maximum up to 50% Sum Insured per eye	**Enhanced Coverage**	☐ Yes ☐ No	**Durable Equipment Cover**	☐ Yes ☐ No
		Unlimited Xtra Recharge of Sum Insured	☐ Yes ☐ No	**Enhanced Road Ambulance Cover**	☐ Yes ☐ No
Surrogacy Cover (Please Fill in the Annexure to proposal form if this cover is opted)	☐ Yes ☐ No	**Oocyte Donor Cover (Please Fill in the Annexure to proposal form if this cover is opted)**	☐ Yes ☐ No	**Room Eligibility cover for Road Traffic Accident**	☐ Yes ☐ No
Bonus Booster Plus	☐ Yes ☐ No	**Infinite Bonus Booster**	☐ Yes ☐ No	**Smart Network Benefit**	☐ Yes ☐ No
Unlimited Care	☐ Yes ☐ No	**Futuristic Cover**	Spouse (with maternity) ☐ Spouse (without maternity) ☐ Spouse (with maternity) + Children ☐ Spouse (without maternity) + Children ☐ Children		

Reduction of Pre-existing disease waiting period	☐ Reduction to 2 Years ☐ Reduction 1 Year ☐ Reduction 1 Day	**Reduction of First Thirty Days waiting period**	☐ Reduction to 7 Days ☐ Reduction to 1 Day	**Reduction of Specific disease Waiting period**	☐ Reduction to 1 Year
Room Rent Modifier	☐ Any Room ☐ Twin Sharing	**Convalescence Benefit**	☐ Yes ☐ No	**Waiver of 'No active line of treatment'**	☐ Yes ☐ No
Modern Treatment Modifier	☐ INR 1,00,000 ☐ Upto Sum Insured	**Freeze Your Price**	☐ Yes ☐ No	**Upgrade Your Coverage**	☐ 20 Lacs ☐ 50 Lacs ☐ 1 Cr
Everything Payable	☐ Yes ☐ No	**Annual Health Check Up Sum Insureds**	☐ Yes ☐ No Option A Up to INR 2,000 OR Option B Up to INR 3,000 OR Option C Up to INR 5,000 OR Option D Up to INR 7,500 OR Option E Up to INR 10,000		

4. DETAILS OF INSURED PERSONS TO BE COVERED

Details	**Insured Person 1**	**Insured Person 2**	**Insured Person 3**	**Insured Person 4**	**Insured Person 5**	**Insured Person 6**
Title						
Name* (First Name)						
(Middle Name)						
(Last Name)						
Gender (M/F/None of these)						
Height* (cm)						
Weight* (kg)						
Eye refractive error index (Left & Right Eye)						
Date of Birth* (DD MM YYYY)						

Details	**Insured Person 1**	**Insured Person 2**	**Insured Person 3**	**Insured Person 4**	**Insured Person 5**	**Insured Person 6**
Relationship with Proposer*	☐ Self ☐ Spouse ☐ Child 1 ☐ Child 2 ☐ Parent / Parent in Law 1 ☐ Parent / Parent in Law 2 ☐ Son-in-law ☐ Daughter-in-law ☐ Grandchild(ren) ☐ Brother ☐ Sister ☐ Other	☐ Self ☐ Spouse ☐ Child 1 ☐ Child 2 ☐ Parent / Parent in Law 1 ☐ Parent / Parent in Law 2 ☐ Son-in-law ☐ Daughter-in-law ☐ Grandchild(ren) ☐ Brother ☐ Sister ☐ Other	☐ Self ☐ Spouse ☐ Child 1 ☐ Child 2 ☐ Parent / Parent in Law 1 ☐ Parent / Parent in Law 2 ☐ Son-in-law ☐ Daughter-in-law ☐ Grandchild(ren) ☐ Brother ☐ Sister ☐ Other	☐ Self ☐ Spouse ☐ Child 1 ☐ Child 2 ☐ Parent / Parent in Law 1 ☐ Parent / Parent in Law 2 ☐ Son-in-law ☐ Daughter-in-law ☐ Grandchild(ren) ☐ Brother ☐ Sister ☐ Other	☐ Self ☐ Spouse ☐ Child 1 ☐ Child 2 ☐ Parent / Parent in Law 1 ☐ Parent / Parent in Law 2 ☐ Son-in-law ☐ Daughter-in-law ☐ Grandchild(ren) ☐ Brother ☐ Sister ☐ Other	☐ Self ☐ Spouse ☐ Child 1 ☐ Child 2 ☐ Parent / Parent in Law 1 ☐ Parent / Parent in Law 2 ☐ Son-in-law ☐ Daughter-in-law ☐ Grandchild(ren) ☐ Brother ☐ Sister ☐ Other
Occupation (Salaried/ Self-employed/ Professional/ Others)						
Optional Cover: Critical Illness Cover	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Optional Cover: Personal Accident Cover	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Sum Insured Personal Accident Cover	☐ 3L ☐ 4L ☐ 5L ☐ 7.5L ☐ 10L ☐ 20L ☐ 25L ☐ 30L ☐ 50L ☐ 75L ☐ 1Cr ☐ 2Cr ☐ 3Cr ☐ 4Cr ☐ 5Cr	☐ 3L ☐ 4L ☐ 5L ☐ 7.5L ☐ 10L ☐ 20L ☐ 25L ☐ 30L ☐ 50L ☐ 75L ☐ 1Cr ☐ 2Cr ☐ 3Cr ☐ 4Cr ☐ 5Cr	☐ 3L ☐ 4L ☐ 5L ☐ 7.5L ☐ 10L ☐ 20L ☐ 25L ☐ 30L ☐ 50L ☐ 75L ☐ 1Cr ☐ 2Cr ☐ 3Cr ☐ 4Cr ☐ 5Cr	☐ 3L ☐ 4L ☐ 5L ☐ 7.5L ☐ 10L ☐ 20L ☐ 25L ☐ 30L ☐ 50L ☐ 75L ☐ 1Cr ☐ 2Cr ☐ 3Cr ☐ 4Cr ☐ 5Cr	☐ 3L ☐ 4L ☐ 5L ☐ 7.5L ☐ 10L ☐ 20L ☐ 25L ☐ 30L ☐ 50L ☐ 75L ☐ 1Cr ☐ 2Cr ☐ 3Cr ☐ 4Cr ☐ 5Cr	☐ 3L ☐ 4L ☐ 5L ☐ 7.5L ☐ 10L ☐ 20L ☐ 25L ☐ 30L ☐ 50L ☐ 75L ☐ 1Cr ☐ 2Cr ☐ 3Cr ☐ 4Cr ☐ 5Cr

Details	**Insured Person 1**	**Insured Person 2**	**Insured Person 3**	**Insured Person 4**	**Insured Person 5**	**Insured Person 6**
Insta Cover Coverage for listed ailments in the policy 1. Asthma 2. Blood Pressure medically known as Hypertension 3. Cholesterol known as Hyperlipidemia 4. Diabetes 5. Obesity 6. Coronary Artery Disease with PTCA 7. Coronary Artery Bypass Graft 8. Chronic Obstructive Pulmonary Disease (COPD) Option to cover 1. All illness (Insta 8) 2. 1st four illness (Insta 4)	☐ Insta 8 ☐ 1st four illness (Insta 4)	☐ Insta 8 ☐ 1st four illness (Insta 4)	☐ Insta 8 ☐ 1st four illness (Insta 4)	☐ Insta 8 ☐ 1st four illness (Insta 4)	☐ Insta 8 ☐ 1st four illness (Insta 4)	☐ Insta 8 ☐ 1st four illness (Insta 4)
Occupation Care Cover	☐ IT Prof ☐ Shop Owners	☐ IT Prof ☐ Shop Owners	☐ IT Prof ☐ Shop Owners	☐ IT Prof ☐ Shop Owners	☐ IT Prof ☐ Shop Owners	☐ IT Prof ☐ Shop Owners
Ayushman Bharat Health Account (ABHA) "I/We hereby give my/our consent to the Company to verify and obtain my/our medical records linked to ABHA."	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
If YES, please indicate the ABHA No.						
If No, Please create your ABHA No https://fasttrack.magmainsurance.com/abha/index						
Resident Status	☐ Resident Indian ☐ Non Resident Indian	☐ Resident Indian ☐ Non Resident Indian	☐ Resident Indian ☐ Non Resident Indian	☐ Resident Indian ☐ Non Resident Indian	☐ Resident Indian ☐ Non Resident Indian	☐ Resident Indian ☐ Non Resident Indian

5. NOMINATION

Policyholder is the nominee for all Insured members. Below details are for nominee to Policyholder*

Name of Nominee:			
	(First Name)	(Middle Name)	(Last Name)
Age:		Gender: ☐ Male ☐ Female ☐ None of these	
Email Id of Nominee:			
Address of the Nominee: (Present / Permanent)			
	City:	Landmark:	
	State:	Pin Code:	
Relationship with Proposer:		Date of Birth: D D M M Y Y Y Y	
Mobile Number of Nominee:		Percentage of Nomination:	
Permanent address of Nominee:			
	City:	Landmark:	
	State:	Pin Code:	

If the Nominee is minor, Name and Address of Appointee and Relationship with Minor:

Appointee Name	Relationship with Nominee	Contact Number of Appointee

Bank Details of Nominee

a) Account Holder(s) Name (As appearing in the Bank Records)			
b) Bank Name		c) Bank Branch Name	
d) Address		e) Branch City	
f) Account Type		g) Account No.	
h) IFSC Code		i) 9 Digit MICR Code	

In case of more than one nominee, please attach a sheet mentioning the details for additional nominees along with the percentages of nomination.

6. EXISTING/PREVIOUS INSURANCE DETAILS

Is the proposer or the persons proposed, already insured under or proposed for a health insurance policy with Magma General Insurance Limited or any other insurance company?

☐ Yes ☐ No

If YES, please indicate below the Policy/ Application number(s) (Please mention application number in case of pending proposal.)

Since when are you continuously insured: D D M M Y Y Y Y

Insured Person Name (First, Middle, Last)	Insurer Name	Policy No./ Application No.	Period of Insurance		Sum Insured (Rs.)	Claims details if any
			From	To		
			DD/MM/YYYY	DD/MM/YYYY		

If you want to avail the portability benefit from your existing insurance policy, please also submit to Us (as an annexure to this proposal form) all the policy documents relating to the existing policy in addition to the information given above.

7. MEDICAL & LIFESTYLE INFORMATION*

Please submit all medical records In case response to any of the below question is YES

SECTION A: Have any of the person proposed to be insured ever suffered from / are suffering from any of the following: Please tick 'YES" for insured person wherever applicable and provide details in Section B.	☐ Yes ☐ No	**Insured Person 1**	**Insured Person 2**	**Insured Person 3**	**Insured Person 4**	**Insured Person 5**	**Insured Person 6**	**Insured Person 7**
1. Hypertension History								
a) Duration								
b) Medication								
c) Dosage								
2. Diabetes Mellitus History								
a) Type 1 or Type 2								
b) Duration								
c) Medication								
d) Dosage								

		Yes / No	Insured Person No.
3.	Heart and Circulatory Conditions/Disorders: chest pain, angina, high cholesterol/lipids, palpitations, congestive heart failure, coronary artery disease, heart attack, bypass surgery/angioplasty, valve disorder/ replacement, pacemaker insertion, rheumatic fever, congenital heart condition, varicose veins, thrombosis, blood disorders etc.?	☐ Yes ☐ No	1 2 3 4 5 6 7
4.	Urinary Conditions/Disorders: Blood in urine, urinary frequency, painful/difficult urination Kidney and/ or Bladder infections, stones of urinary system, renal failure, dialysis or Any Other Kidney/Urinary Tract Or Prostate Disease	☐ Yes ☐ No	1 2 3 4 5 6 7
5.	Musculoskeletal Conditions/Disorders: Joint/back pain Arthritis, Spondylosis, Joint Replacement Or Any Other Disorder of Muscle/ Bone/ Joint/ligaments, tendons or discs, gout, herniated disc, amputation/prosthesis	☐ Yes ☐ No	1 2 3 4 5 6 7
6.	Respiratory Conditions/Disorders: Shortness/difficulty of breath, Tuberculosis, Asthma, Bronchitis, Chronic Obstructive Pulmonary Disease COPD, chronic cough , coughing of blood, etc or any Other Lung / Respiratory Disease	☐ Yes ☐ No	1 2 3 4 5 6 7
7.	Digestive Conditions/Disorders: Jaundice, chronic diarrhea, intestinal bleeding/problems/polyps, diseases of the pancreas, liver or gall bladder, hepatitis A/B/C/other, jaundice, Cirrhosis, unexplained weight loss or gain, eating disorder or any Other Gastro Intestinal condition	☐ Yes ☐ No	1 2 3 4 5 6 7
8.	Cancer/Tumor - Benign Or Malignant tumor, Any Growth/Cyst, any Cancer	☐ Yes ☐ No	1 2 3 4 5 6 7
9.	Brain/Nervous System/ Psychiatric Conditions/Disorders: Loss of consciousness, fainting, dizziness, numbness/ tingling, weakness, paralysis, head injury, stroke, migraine headaches or chronic severe headaches, sleep apnea, multiple sclerosis, seizures/epilepsy or any Other Brain/ Nervous System Disease, Mental/Psychiatric disorder	☐ Yes ☐ No	1 2 3 4 5 6 7
10.	Female Reproductive Conditions/Disorders: Pelvic pain, abnormal, menstrual bleeding abnormal PAP smear, endometriosis, Fibroid, Cyst/ Fibroadenoma, Bleeding Disorder, Pelvic infection Or Any Other Gynecological / Breast cysts/lumps/tumor	☐ Yes ☐ No	1 2 3 4 5 6 7
11.	Is any female person proposed to be insured pregnant, tested positive with a home pregnancy test, or in the process of adoption or becoming a surrogate?	☐ Yes ☐ No	1 2 3 4 5 6 7
12.	Metabolic and Endocrine Conditions/Disorders: Adrenal/pituitary disorders, lupus, scleroderma, thyroid disorders, any autoimmune/genetic disorder	☐ Yes ☐ No	1 2 3 4 5 6 7

13.	Does the person proposed to be insured suffer from any chronic or long-term medical condition, or have any other disability, abnormality or recurrent illness or injury or unable to perform normal activities?	☐ Yes ☐ No	1 2 3 4 5 6 7
14.	Does the person proposed to be insured use tobacco products/cigarettes or drinks alcohol?	☐ Yes ☐ No	1 2 3 4 5 6 7
15.	Does any of the person proposed to be insured suffers from any infertility related condition?	☐ Yes ☐ No	1 2 3 4 5 6 7
16.	Has any person proposed to be insured consulted with or received treatment from any doctor or other health care provider for any other condition or symptom(s)/any psychiatric condition/ undergone any hospitalization/ illness/surgery/ currently taking medication(s) for any condition or medical procedures (including diagnostic testing)	☐ Yes ☐ No	1 2 3 4 5 6 7
17.	Have you or any of the persons proposed to be insured been diagnosed with or undergone surgery for any of the following Critical Illnesses, prior to proposing for this cover - Cancer, Heart Attack, Coronary Artery, Bypass Graft, Heart Valve Replacement/ Repair, Coma, Kidney Failure, Stroke, any Transplant, Paralysis, Multiple Sclerosis, Motor Neurone Disease or HIV/AIDS	☐ Yes ☐ No	1 2 3 4 5 6 7
For Personal Accident Cover		☐ Yes ☐ No	1 2 3 4 5 6 7
18.	Has any of the applicants suffered or currently suffering from seizure disorder or any physical or mental defects/ impairment/ infirmity/deformity or any condition that may effect mobility/ sight/hearing/speech?	☐ Yes ☐ No	1 2 3 4 5 6 7
19.	Does the applicant's occupation require him/her to engage in hazardous activities or handling hazardous material or working at heights, as cabin crew, in sea/river faring vessels, with high voltage, or be a part of armed forces?	☐ Yes ☐ No	1 2 3 4 5 6 7

SECTION B: Name and details of Illness / Medicine / Test / Surgery / Diopter grade (for questions answered as yes in SECTION A above)	**Date of Last Consultation**	**Doctor's Name**	**Hospital Name & Phone No.**
Insured Person 1:			
Insured Person 2:			
Insured Person 3:			
Insured Person 4:			
Insured Person 5:			
Insured Person 6:			
Insured Person 7:			

Any other details : _____

Please add additional sheets if required.

Section C: Important Notes:

1. The information that you give to Us on this proposal form or in any supplementary information form or documentation supplied by you or on your behalf will influence Our decision to offer insurance and the terms upon which to offer it. Further, any policy We issue will be based on what you have communicated to Us. It is therefore important that your answers are complete and accurate in all respects.
2. The questions in this proposal are indicative rather than exhaustive. You must provide Us with all information relevant to the risk to be insured, even if it is not the subject of a question in this proposal. If you are in any doubt as to what information should be given, you should liaise with your insurance advisor/ company.
3. Acceptance of your proposal would be subject to receipt of complete medical reports (wherever applicable), medical underwriting and the insurance coverage will commence after realization of full premium amount by the company.
4. The list of exclusions/ inclusions and other policy details are indicative, for complete list and comprehensive details kindly refer policy wordings.

Section D: Family Physician details:

Name	
Contact No.	

8. PAYMENT DETAILS

1. **Payment Details: Please tick (✓) payment option** Premium Amount (Rs) _____

   ☐ Cash ☐ Cheque/NEFT/DD Payment Option ☐ Digital Payment

   Cheque/NEFT/DD Number _____ Cheque/NEFT/DD Date: D D M M Y Y Y Y

   Bank _____

2. **For payment of claims/refund through direct bank transfer, please provide the following details*: (please enclose a cancelled cheque along with the proposal form)**

   Name of the bank _____

   Branch _____ City _____

   IFSC Code _____ Account Number _____

   Account Type _____

Declaration:

"I/We hereby declare and undertake that the amount paid by me/us as premium for aforementioned policy is out of my/our lawful and declared source of income."

Electronic Clearing Service (Debit Clearing) Mandate Form

Proposal No. _____ Policy: _____

To,
Magma General Insurance Ltd., Equinox Business Park, Tower 3, Ambedkar Nagar, 2nd Floor,
Unit Number 1B & 2B, LBS Marg, Kurla (West), Mumbai - 400070, Maharashtra, India

Ref: Authorization of customer to remit funds/payments to <Bank Name> through Electronic Clearing Service

Customer Information:

a) Account Holder(s) Name (As appearing in the Bank Records			
b) Bank Name		c) Bank Branch Name	
d) Address		e) Branch City	
f) Account Type		g) Account No.	
h) Ledger No./Ledger Folio No.		i) 9 Digit MICR Code	

Declaration:

I wish to avail the electronic clearing facility and hereby express my unconditional consent to debit premium for my health insurance policy applied vide proposal form no. _____ through participation in Electronic Clearing System (ECS). I, understand and agree that premium amount to be debited from my account may vary due to change in age bracket of the senior most member insured under the policy, change in applicable premium rates by the insurer, taxes and other statutory levies as may be applicable from time to time.

(Please refer to policy documents for approximate premium details due to change in age applicable at the time of renewal)

I, hereby declare that the particulars given are correct and complete. I understand and accept that the transaction will be effected on the due date as opted by me in this form subject to the payment of premium on the policy (provided the day is a working day). If the transaction is delayed or not effective at all for reasons of incomplete or incorrect information, I/we would not hold the user institution responsible. I/We have read all the terms and conditions as are applicable for availing of this ECS Debit service from/through the user institution and agree to discharge the responsibility expected of me/us as a participant under the scheme.

I/We also hereby authorize representative of Magma General Insurance Ltd. carrying this ECS Debit Mandate Form to get it verified and executed by my/our Bank.

Place:_____ Date: D D M M Y Y Y Y

_____
Signature of applicant

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

9. ELECTRONIC INSURANCE DETAILS OF PROPOSER

Do you wish to have this Policy credited to an eIA? (Please select any one)

☐ No, I do not have an eIA and do not wish to open one

☐ Yes, Credit this Policy to my e-Insurance account

If yes, Please share existing e-Insurance Account No.: _____

Please select Insurance Repository Name (you have opened your account with)

☐ M/s NSDL Database Management Limited

☐ M/s Karvy Insurance Repository Limited

☐ M/s Central Insurance Repository Limited

☐ M/s CAMS Repository Services Limited

☐ M/s SHCIL Projects Limited (Please select any one)

Or

I do not have existing e-Insurance account and I am interested in creating a new e-Insurance account. (Please submit electronic insurance account opening form (eIA form) along with relevant documents)

My CKYC No. (Central Know Your Customer registry number) is (if available): _____

Representative Details (only if eIA is to be opened for any other person other than Proposer and primary Insured)

Name (Mr./Ms./Mrs./Other)			
	(First Name)	(Middle Name)	(Last Name)
Gender:	☐ Male	☐ Female	☐ None of these
Date of Birth:	D D M M Y Y Y Y	PAN:	
Address Line 1:			
	Landmark:	State:	
	City:	Country:	Pin Code:
	Relationship:	Other Relationship:	
Telephone Number:	STD Code:	Landline No.:	Mobile No.*
E Mail ID:			UID:
Address Line 2:			
	Landmark:	State:	
	City:	Country:	Pin Code:
	Relationship:	Other Relationship:	
Telephone Number:	STD Code:	Landline No.:	Mobile No.*
E Mail ID:			UID:
Address Line 3:			
	Landmark:	State:	
	City:	Country:	Pin Code:
	Relationship:	Other Relationship:	
Telephone Number:	STD Code:	Landline No.:	Mobile No.*
E Mail ID:			UID:

10. DECLARATIONS

1. 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.

Date: D D M M Y Y Y Y

Signature of the Proposer: _____

Place: _____

Name of Proposer: _____

2. Authorization for electronic policy fulfillment and service communications

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: _____

3. 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

4. Intermediary Declaration

I, _____ (Full Name) in my capacity as a SP/POSP/BQP/ Designated Person/ Authorized Verifier/ Authorized Salesperson of the Corporate Agent/ Broker/IMF/Web Aggregators, 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.

Functional/Unique ID (SP/POSP/BQP/DP/AV/ASP): _____

Branch Mobile/Phone Number: _____ Branch Email Address: _____

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: _____

5. 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: _____

6. AML Guidelines

I/we hereby confirm that all premiums paid / payable in future will be 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: D D M M Y Y Y Y Signature of the Proposer: _____

Are you or any of the proposal applicant are PEPs* or a 'close associates', 'family members' of PEPs*?

☐ Yes ☐ No

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

* Politically Exposed Persons' (PEPs) are individuals who are or have been entrusted with prominent public functions in a foreign country, including the Heads of States/Governments, senior politicians, senior government/judicial/military officers, senior executives of state-owned corporations, important political party officials, etc.

Policy holder type / Proposer type:

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

Source of Funds:

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

8. Disability Declaration

"I _____ (Name of the Proposer) certify that the Proposal Form has been filled as per the information provided by me. I, authorise _____ (Full name of the representative) who is my _____ (Relationship with the Proposer), an adult and residing at _____ _____ (Address) act as my representative to assist and fill this proposal form and give the necessary declarations on my behalf.

Signature of Proposer: _____

I _____ (Name of the Representative) do hereby certify that I have read out and explained the contents of the Proposal Form and all other documents required to avail this insurance policy with Magma General Insurance, to the Proposer and they have understood the same. I declare that the facts stated herein are true and correct to the best of my knowledge and belief.

Signature of the Representative: _____

11. GENERAL INFORMATION

1. Caution

You are obliged to make a full and frank disclosure of all facts material to the assumption of risk in relation to you and every person proposed to be insured that would influence Our decision to issue the policy or the terms on which it is issued and you must not misrepresent any information to Us. The obligation continues until the policy is issued and does not end with the submission of this proposal form. If, therefore, there is any change in the information given herein or new information comes to light before the policy is issued, then you must inform Us of the same in writing without delay. If there is insufficient space to provide additional information, whether as requested or otherwise, then please attach an extra sheet duly signed. If the disclosure obligations are breached then such breach may render any policy issued void.

Prohibition of Rebates Under Section 41 of Insurance Law (Amendment) Act, 2015

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. Any person making default in complying with the provisions of this section shall be liable for a penalty which may extend to ten lakh rupees.
2. Provided that acceptance by an insurance agent of commission in connection with a policy of any class of insurance business taken out by himself in relations to risks associated with his own life, health or property shall not be deemed to be acceptance of a rebate of premium within the meaning of this sub-section if at the time of such acceptance the insurance agent satisfies the prescribed conditions establishing that he is a bona fide insurance agent employed by the insurer.

Acknowledgment

Proposal No. _____ Date: D D M M Y Y Y Y

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 _____