MAGMA General Insurance Limited

PROPOSAL FORM - ONECLICK OPD

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*

Gram Panchayat Name

City **Landmark**

State **Pin Code**

Phone No. STD Code **Landline No.** **Mobile No.***

GST Number

E Mail ID*

MAGMA General Insurance Limited

PROPOSAL FORM - ONECLICK OPD

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 differently abled, please provide the below details which will enable us to provide necessary accessible services to you.

Type of Impairment			
Percentage of Impairment			
UDID (Unique Disability ID) Number			
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	**Policy Period**	☐ 1 Year ☐ 2 Year ☐ 3 Year
If Family Floater*, number of persons to be covered: Adults: ____Children:___		**Premium Payment Frequency**	☐ Single Premium ☐ Monthly Instalment ☐ Quarterly Instalment ☐ Semi-annual Instalment
Plans / Sum Insured options		☐ Even OPD Vital ☐ Even OPD Lite ☐ Even OPD Advance	Unlimited Cashless ☐ 200,00 ☐ 300,00 ☐ 400,00 ☐ 500,00 ☐ Unlimited ☐ 200,00 ☐ 300,00 ☐ 400,00 ☐ 500,00 ☐ Unlimited

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	Insured Person 7	Insured Person 8
Title								
Name*								
Gender (M/F/None of these)								
Height* (cm)								
Weight* (kg)								
Eye refractive error index (Left & Right Eye)								
History of Smoking	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
Date of Birth* (DD MM YYYY)								
Relationship with Proposer*								
Occupation (Salaried/Self-employed/ Professional/ Others)								
Optional Cover:Additional Pharmacy cover	☐ Up to ₹ 1000 ☐ Up to ₹ 2000 ☐ Up to ₹ 5000	☐ Up to ₹ 1000 ☐ Up to ₹ 2000 ☐ Up to ₹ 5000	☐ Up to ₹ 1000 ☐ Up to ₹ 2000 ☐ Up to ₹ 5000	☐ Up to ₹ 1000 ☐ Up to ₹ 2000 ☐ Up to ₹ 5000	☐ Up to ₹ 1000 ☐ Up to ₹ 2000 ☐ Up to ₹ 5000	☐ Up to ₹ 1000 ☐ Up to ₹ 2000 ☐ Up to ₹ 5000	☐ Up to ₹ 1000 ☐ Up to ₹ 2000 ☐ Up to ₹ 5000	☐ Up to ₹ 1000 ☐ Up to ₹ 2000 ☐ Up to ₹ 5000

Details	Insured Person 1	Insured Person 2	Insured Person 3	Insured Person 4	Insured Person 5	Insured Person 6	Insured Person 7	Insured Person 8
Optional Cover: Physiotherapy sessions	4/8/12 sessions	4/8/12 sessions	4/8/12 sessions	4/8/12 sessions	4/8/12 sessions	4/8/12 sessions	4/8/12 sessions	4/8/12 sessions
Optional Cover: OP Procedure	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
Optional Cover: Dental Care	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
Optional Cover: Maternity Coverage	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
Optional Cover: Increase in Pre-Existing Disease waiting periods	☐ 1 yr ☐ 2 yrs ☐ 3 yrs	☐ 1 yr ☐ 2 yrs ☐ 3 yrs	☐ 1 yr ☐ 2 yrs ☐ 3 yrs	☐ 1 yr ☐ 2 yrs ☐ 3 yrs	☐ 1 yr ☐ 2 yrs ☐ 3 yrs	☐ 1 yr ☐ 2 yrs ☐ 3 yrs	☐ 1 yr ☐ 2 yrs ☐ 3 yrs	☐ 1 yr ☐ 2 yrs ☐ 3 yrs
Ayushman Bharat Health Account (ABHA)	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
"I/We hereby give my/our consent to the Company to verify and obtain my/our medical records linked to ABHA."								
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	☐ 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 Middle Last

Age ☐☐ yrs **Gender** ☐ Male ☐ Female ☐ Third Gender

Email Id of Nominee .....

Address of the Nominee (Present / Permanent)

City **Landmark**

State **Pin Code**

Phone No. STD Code **Landline No.** **Mobile No.***

Relationship with Proposer **Date of Birth** D D M M Y Y Y Y

Percentage of Nomination

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 (₹)	Claims details if any
			From	To		
			DD/MM/YYYY	DD/MM/YYYY		
			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

Sr. No		Yes/No	Insured Person No
1	Does any member of the family have hypertension (high blood pressure)?	☐ Y ☐ N	1 2 3 4 5 6 7 8
2	Has any member of the family ever been hospitalized due to hypertension?	☐ Y ☐ N	1 2 3 4 5 6 7 8
3	For any affected member, what is the duration of hypertension (in years)?	☐ Y ☐ N	1 2 3 4 5 6 7 8
4	Has any member developed complications due to hypertension, such as heart attack, heart failure, stroke, eye damage (retinopathy), chronic kidney disease (CKD), aneurysms, or dementia?	☐ Y ☐ N	1 2 3 4 5 6 7 8
5	Does any member of the family have diabetes mellitus?	☐ Y ☐ N	1 2 3 4 5 6 7 8
6	Has any member ever been hospitalized for diabetes, been on insulin treatment, or had diabetic foot or foot ulcers?	☐ Y ☐ N	1 2 3 4 5 6 7 8
7	For any affected member, what is the duration of diabetes (in years)?	☐ Y ☐ N	1 2 3 4 5 6 7 8
8	Has any member developed complications of diabetes such as heart disease, stroke, vision loss (retinopathy), kidney disease (nephropathy), nerve damage (neuropathy), foot problems, digestive issues, or recurrent infections?	☐ Y ☐ N	1 2 3 4 5 6 7 8
9	Please mention the latest HbA1c or fasting blood sugar (FBS) value for any affected member, if available.	☐ Y ☐ N	1 2 3 4 5 6 7 8
10	Does any member of the family have heart or circulatory conditions such as angina, heart attack, heart failure, coronary artery disease, bypass surgery or angioplasty, valve disease or replacement, pacemaker implantation, congenital heart disease, varicose veins, thrombosis, or blood disorders?	☐ Y ☐ N	1 2 3 4 5 6 7 8
11	Does any member of the family have urinary or kidney-related conditions such as blood in urine, frequent or painful urination, kidney or bladder infections, urinary stones, renal failure, dialysis, or prostate disease?	☐ Y ☐ N	1 2 3 4 5 6 7 8
12	Does any member of the family have chronic kidney disease, proteinuria, nephritis, neurogenic bladder, pyelitis or pyelonephritis, urethral or ureteric stricture or stenosis, urethritis, vesico-ureteral reflux disease, nephrotic syndrome, or have they undergone or been advised nephrectomy or long-term catheter use for urinary incontinence?	☐ Y ☐ N	1 2 3 4 5 6 7 8

Sr. No		Yes/No	Insured Person No
13	Does any member of the family have musculoskeletal conditions such as joint or back pain, arthritis, spondylosis, joint replacement, gout, herniated disc, amputation or prosthesis, or any disorder of muscles, bones, joints, ligaments, tendons, or discs?	☐ Y ☐ N	1 2 3 4 5 6 7 8
14	Does any member of the family have respiratory or lung conditions such as shortness of breath, tuberculosis, asthma, bronchitis, chronic obstructive pulmonary disease (COPD), chronic cough, coughing up blood, or any other respiratory disease?	☐ Y ☐ N	1 2 3 4 5 6 7 8
15	Has any member been diagnosed with asbestosis, emphysema, chronic obstructive pulmonary disease (COPD), silicosis, respiratory tract polyps or papilloma's, or sarcoidosis?	☐ Y ☐ N	1 2 3 4 5 6 7 8
16	Does any member of the family have digestive or gastrointestinal conditions such as chronic diarrhoea, intestinal bleeding or polyps, pancreatic, liver or gall bladder disease, hepatitis (A, B, or C), cirrhosis, unexplained weight loss or gain, irritable bowel syndrome (IBS), Crohn's disease, or any other gastrointestinal condition?	☐ Y ☐ N	1 2 3 4 5 6 7 8
17	Has any member been diagnosed with conditions such as achalasia cardia, Barrett's oesophagus, celiac disease, cirrhosis of liver, colitis, Crohn's disease, diverticulitis, oesophageal stricture, hepatitis B or C, pancreatitis, polyps or papillomas, ulcerative proctitis, oesophagitis, volvulus, diverticular disease, intestinal malabsorption, alcoholic liver disease, hepatic failure, autoimmune hepatitis, mesenteric thrombosis, intestinal perforation, or intestinal obstruction?	☐ Y ☐ N	1 2 3 4 5 6 7 8
18	Does any member of the family have or have had cancer or any malignant tumor?	☐ Y ☐ N	1 2 3 4 5 6 7 8
19	Does any member of the family have neurological or psychiatric conditions such as fainting, dizziness, numbness or tingling, weakness, paralysis, head injury, stroke, migraine or chronic severe headaches, sleep apnoea, multiple sclerosis, seizures or epilepsy, or any mental or psychiatric disorder?	☐ Y ☐ N	1 2 3 4 5 6 7 8
20	Does any female member of the family have gynaecological or breast conditions such as pelvic pain, abnormal menstrual bleeding, abnormal PAP smear, endometriosis, fibroids, cysts, fibroadenoma, bleeding disorders, pelvic infections, or breast lumps or tumours?	☐ Y ☐ N	1 2 3 4 5 6 7 8
21	Does any Member in the family have High Cholestrol	☐ Y ☐ N	1 2 3 4 5 6 7 8
22	Has any member's lipid profile ever been above the threshold (Total Cholesterol >250 mg/dL, LDL >160 mg/dL, or Triglycerides >450 mg/dL)?	☐ Y ☐ N	1 2 3 4 5 6 7 8
23	Please mention the latest total cholesterol or LDL value for any affected member, if available.	☐ Y ☐ N	1 2 3 4 5 6 7 8
24	Does any member of the family have metabolic, endocrine, or autoimmune conditions such as adrenal or pituitary disorders, thyroid disorders, lupus, scleroderma, or any autoimmune or genetic disorder?	☐ Y ☐ N	1 2 3 4 5 6 7 8
25	Do any members currently have undiagnosed symptoms such as chest pain, weakness, weight loss, dizziness, joint pain, change in bowel habits, difficulty in breathing, abdominal pain, or pain or bleeding while passing stools?	☐ Y ☐ N	1 2 3 4 5 6 7 8
26	Does any member of the family use tobacco products or consume alcohol?	☐ Y ☐ N	1 2 3 4 5 6 7 8
27	Frequency of Smoking	☐ Y ☐ N	1 2 3 4 5 6 7 8
28	Frequency of Alcohol Consumption	☐ Y ☐ N	1 2 3 4 5 6 7 8
29	Does any member chew tobacco regularly or have symptoms such as burning sensation in the mouth, mouth ulcers, reduced mouth opening, or discoloration of the oral lining?	☐ Y ☐ N	1 2 3 4 5 6 7 8
30	Does any member of the family currently take medications, or have they been prescribed medication or treatment for more than 7 consecutive days in the last 3 years (excluding common cold or flu and conditions already disclosed)?	☐ Y ☐ N	1 2 3 4 5 6 7 8

Sr. No		Yes/No	Insured Person No
31	Has any member consulted a doctor, received treatment, undergone hospitalisation or surgery, taken medications, or undergone diagnostic procedures for any other medical or psychiatric condition?	☐ Y ☐ N	1 2 3 4 5 6 7 8
32	Has any member been diagnosed with or undergone surgery for any critical illness such as cancer, heart attack, coronary artery bypass, heart valve replacement or repair, coma, kidney failure, stroke, any transplant, paralysis, multiple sclerosis, motor neurone disease, or HIV/AIDS?	☐ Y ☐ N	1 2 3 4 5 6 7 8
33	Has any member suffered from seizures or any physical or mental impairment affecting mobility, vision, hearing, or speech?	☐ Y ☐ N	1 2 3 4 5 6 7 8
34	Have any members undergone medical tests in the last 3 years (blood tests, X-ray, ECG, TMT, ultrasound, mammogram, MRI/CT scan, PET scan, etc.) other than routine check-ups?	☐ Y ☐ N	1 2 3 4 5 6 7 8
35	Does any member of the family have HIV, AIDS, or any sexually transmitted disease (STD)?	☐ Y ☐ N	1 2 3 4 5 6 7 8
36	Does any member of the family have any blood or immune system disorder?	☐ Y ☐ N	1 2 3 4 5 6 7 8
37	Does any member of the family have any congenital (by birth) disorder?	☐ Y ☐ N	1 2 3 4 5 6 7 8
38	Does any member of the family have any other illness or medical condition not mentioned above?	☐ Y ☐ N	1 2 3 4 5 6 7 8
39	Has any member been diagnosed with or hospitalised for any illness or injury in the last 48 months?	☐ Y ☐ N	1 2 3 4 5 6 7 8
40	Have any of the person(s) to be insured ever filed a claim with their current / previous insurer?	☐ Y ☐ N	1 2 3 4 5 6 7 8
41	Has any proposal(s) for health insurance of the new person(s) to be insured, been declined cancelled or charged a higher premium?	☐ Y ☐ N	1 2 3 4 5 6 7 8
42	Have you had any adverse finding to any diagnostic test or procedures, have symptoms or complaints needing doctors consultation, been advised or had been hospitalized for more than 5 days in total, or undergone any surgery in the last 12 months? If yes, please provide details in the additional information section below.	☐ Y ☐ N	1 2 3 4 5 6 7 8

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:			
Insured Person 8:			

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

Please tick mode of payment option: ☐ Cash ☐ Cheque / NEFT/DD Payment Option ☐ Digital Payment ☐ UPI

Cheque/NEFT/DD Number | Cheque/NEFT/DD Date D D M M Y Y Y Y

Bank | Amount in figures (Rs.)

Amount in words (Rs) _____

BIMA ASBA Declaration (Applicable only in case Premium payment through online payment mode)

☐ I hereby accord my consent to authorize the Company to block the applicable premium payable for the aforesaid insurance policy under the BIMA ASBA facility and debit the same from my bank account upon acceptance of this proposal. In case the proposal is not accepted, I accord my consent to debit only the expenses incurred towards medical examination, if any, and unblock the balance amount

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: _____

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)

First Name Middle Name Last Name

Gender: ☐ Male ☐ Female ☐ Third Gender DOB: D D M M Y Y Y Y

PAN:

Address Line 1:

Address Line 2:

Address Line 3:

Pin code: Telephone Number: Mobile Number:

Relationship: Other Relationship:

Email Id:

UID:

Landmark: State:

City: Country:

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 the 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.

Signature of the Proposer: _____ Date: D D M M Y Y Y Y

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:

☐ Individual ☐ Corporations ☐ Trust (Darpan ID: _____)
☐ Government ☐ Partnership ☐ Non-Government Organisations ☐ Co-operatives
☐ Society ☐ Private Limited Company ☐ Public Limited Company
☐ Others, please specify _____

Source of Funds:

☐ Business ☐ Salaried ☐ Others (please specify) _____

7. **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 41of 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 (For office use only)

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