Liberty General Insurance Ltd.
Unit 1501&1502, 15th Floor, Tower 2, One International Center,
Senapati Bapat Marg, Prabhadevi, Mumbai – 400013,
Phone: +91 226700 1313 Fax: +91 226700 1606
IRDAI of India Reg. No.150, CIN: U66000MH2010PLC269656

Liberty Complete Protect Group Policy
Proposal Form

URN - LH011V022024

The acceptance of the proposal is subject to receipt of the total premium and realization of payment will be as per the policy terms and conditions. Kindly fill the form completely in CAPITAL LETTERS to help us to serve you better. The Company is under no obligation to accept this Proposal. Receipt of this Proposal by the Company along with the premium payment & medical reports, if applicable, does not tantamount to the acceptance of the Proposal by the Company and does not result in a concluded contract of insurance. Coverage is as per the terms and conditions of our Standard Policy Wordings. The Policy shall become voidable at the option of the Insurer, in the event of any untrue or incorrect statement, misrepresentation, non-description, failure to disclose or suppression of any material facts in response to the questions in the proposal form or on non-disclosure of any material particular.

1. Company/ Proposer/Financier/Bank Details

Name of Entity / Proposer:

Address:

Industry Type:

Contact Person:

Designation:

Designated Email Address: **Fax:** **Contact No/Mobile No:**

2. Proposal Details

Business Type: New ☐ Renewal ☐ Rollover ☐

Proposed Policy Period: **From** | d | d | M | M | y | y | y | Y | **To** | d | d | m | m | y | y | y | y |

Total No. of Members: _____

3. Proposed Covers

Detailed Coverage	Please tick (✓) the Proposed cover				Please mention the Limits Proposed			
	Insured-1	Insured-2	Insured-3	Insured-4	Insured-1	Insured-2	Insured-3	Insured-4
Section I – Daily Hospital Cash Benefit								
Daily Hospital Cash Benefit – Illness/Injury								
Daily Hospital Cash Benefit – Only Accidents								
Single event No of days Limit								
Multiple Event Maximum No of days Limit								
Double ICU Benefit – Sickness								
Double ICU Benefit – Only Accidents								
Day Care Procedure Cash								
Deductible								
Family Floater Cover								
Waiting Period Waiver								
Hospitalisation due to Maternity								
Pre and Post natal Hospitalisation								
ISection II – Personal Accident Benefit								
Benefit Opted (AD/PTD/PPD/TTD)								
Child Education Support								
Accidental Medical Expenses								
Transportation of Mortal Remains								
Performance of Funeral Ceremony								
Modification of Residence/ Vehicle								
Ambulance Hiring Charges								
PTD Enhanced Option								
Accidental Hospitalization Expenses (Inpatient)								
Accidental Hospitalization Expenses (Outpatient)								
Coma of Specified Severity								
Burns Cover								
Broken Bones								
Vacation Cancellation Cover								
Return to Home Benefit								
Section III – Critical Illness Benefit								
Critical Illness Benefit (Plan Details)								
Option to reduce Survival Period								
Waiting Period Waiver								
Second Opinion Cover								
Section IV – Vector Borne Diseases Benefit								
In-patient Hospitalization Benefit								
Double Vector Borne Diseases Benefit								
Waiting Period Waiver								
Section V – EMI Protector Benefit								
In Patient Hospitalisation Benefit								
Personal Accident Benefit								
Critical Illness Benefit								
Vector Borne Diseases Benefit								
Waiting Period Waiver								
Option to reduce Survival Period for CI								
Section VI – Loan Protector Benefit								
Personal Accident Benefit								
Critical Illness Benefit								
Critical Illness Plan								
Waiting Period Waiver								
Option to reduce Survival Period for CI								

Section VII – Infectious Diseases Benefit								
Set A: Infectious diseases								
Set B: HIV Infection								
Set C: Covid Infection								
Waiting Period Wavier								
Sum Insured Type (Common / Separate)								
Coverage Type (Diagnosis / Hospitalisation)								
Section VIII – Income Protection Benefit								
Loss of Income due to Disability								
Loss of Income Due to Critical Illness								
Critical Illness - Plan								
Waiting Period Wavier								
Option to reduce Survival Period for CI								
Optional Cover								
Surgical Benefit Cover								
Maternity Benefit Cover								
Double Maternity Benefit Cover								
Joint hospitalization Cover								
Convalescence Benefit								

4. Proposed Insured Person(s) Details format

Name	Contact No.	Email Address	Occupation	Loan Account no.	DOB	Gender	Nationality	Relationship with Primary Insured	Sum Insured	Pre-existing Disease	Height (cm)	Weight (kg)	Loan Amount	Purpose of Loan	Annual Income	Loan Tenure	EMI Amount	PAN No.	Nominee / Assignee Name	Relationship with Nominee / Assignee

Medical and Lifestyle related Information:

Part-A

Name	Loan Account no.	DOB	Gender	Suffering /suffered from any disease / illness / Injury	Suffering/suffered/treated for any heart related ailment / blood pressure / Diabetes / Cancer	Suffering /suffered from Paralysis / Asthma / Epilepsy	Any present/past history of surgery/medication/disability/ medical condition	Consumption of Alcohol / Smoke / Pan Masala / others	If answer to any questions is Yes, please elaborate				
									Name of illness / injury suffering from or suffered in the past	Date of first diagnosed / detected	Treatment / medication received / receiving	Details of Hospitalization (If any)	Is it fully cured
				Yes ☐ No☐	Yes ☐ No☐	Yes ☐ No☐	Yes ☐ No☐	Yes ☐ No☐					

Part-B

Have any of the proposed insured ever suffered from/currently suffering from any of the following	**Self**	**Spouse**	**Child-1**	**Child-2**
HIV/AIDS/any sexually transmitted disorder				
Psychiatric/mental illness or sleep disorders				

(Individual member details to be furnished by way of annexure provided)

5. Additional Information (If any)

_____
_____
_____
_____

6. Previous/Existing Insurance Details (if any)

Year	Previous Policy Terms and Conditions	Premium	Claim Details								Group Size
			Claims Paid		Claims O/s		Claims Rejected		Claims Closed		
			No.	Amount	No.	Amount	No.	Amount	No.	Amount	
Year 1											
Year 2											
Year 3											
Year 4											
Year 5											

7. Payment details

Instrument type (Cash/Cheque/DD/Others)	**Name of the premium payer**	**Bank Name**	**Cheque Date**	**Amount in Rs**

Please make an A/C Payee Cheque / DD / Pay Order in favour of 'Liberty General Insurance Limited' only

For NEFT Payments, please fill the Bank details mentioned below:

Bank Name																	
Branch																	
City																	
Account No																	
IFSC Code																	

Account Type: Savings ☐ **Current** ☐

AML Details:

Please provide Permanent Account Number (PAN) if premium amount exceeds Rs. 1 Lac _____

☐ I/We hereby declare that the premium for the said policy is paid out of the legally declared and assessed sources of my/our income OR

☐ I/We hereby declare that the premium is paid from the Bank Account of Mr. /Ms._____ the payment is allowed under the Income Tax Act 1961, and there is insurable interest with the payee.

☐ I/ We hereby confirm that all premiums are paid from bonafide sources and no premium have been paid out of the proceeds of crime related to any of the offence listed in Prevention of Money Laundering Act 2002 and its subsequent amendments thereof. I/We understand that the company has the right to call for the documents to establish source of funds. The Company has the right to cancel the insurance contract in case I am/We have been found guilty by any competent court of law under any of the statues, directly/ indirectly governing the prevention of Money Laundering in India.

8. Declaration

☐ I/We 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/We am/are authorised 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 board approved underwriting policy of the Insurer and that the policy will come into force only after full payment of the premium Chargeable.

☐ I/We further declare that insured represented under this proposal forms group within the meaning of the group guidelines issued by IRDAI and the group is formed for the purpose other than obtaining the insurance policy.

☐ I/We further declare that I/We will notify in writing any change occurring in the occupation or general health of the life to be insured after the proposal has been submitted but before communication of the risk acceptance by the Company.

☐ I/We declare and consent to the company seeking medical information from any doctor or from the hospital who at any time has attended on the life to be insured/insured person or from any past or present employer concerning anything which affects the physical and mental health of the life to be insured/insured person and seeking information from any Insurer to whom an application for insurance on the life to be insured/insured person has been made for the purpose of underwriting the proposal and/or claim settlement.

☐ I/We authorise the Company to share information pertaining to my proposal including the medical records of the life to be insured/insured person for the sole purpose of proposal underwriting and/or claims settlement and with any Government and/or Regulatory Authority.

☐ We understand that the Master Cover shall become void at the Company's option, in the event of any untrue or incorrect statement, misrepresentation, misdeclaration, non-description or non-disclosure of any material fact in the Proposal form/personal statement, declaration and corresponding documents or any material information having been withheld by us or anyone acting on our behalf.

☐ We consent to receive information from the Company through physical, electronic or telecommunication means from time to time.

☐ I hereby declare that the above statements, answers and/or particulars given by me in this proposal form are true and complete in all respects to the best of my knowledge and that I am authorized to propose on behalf of the Master Cover Holder. I/We hereby declare that, in case any of the statement provided hereinabove is found to be false or misrepresentation, the Company at its option may terminate the Insurance Policy, forfeiting the premium paid by me/us under the said Policy. The Company may also initiate such action against me/us as it may deem appropriate in the event of me/us furnishing any false statement or in case of any misrepresentation by me/us in connection with obtaining the insurance policy from the Company.

☐ I/We hereby give voluntary consent to Liberty General Insurance Limited/Company to process/share my/our personal information and data provided in this form with its group companies or any other person/ Service Provider of Company in connection with the Insurance Policy/ claims made there under or otherwise, including for providing other products of the Company that may be of interest to me/us, to be used in accordance with their respective privacy policies.

Date **Signature of Proposer/Authorized signatory**

DECLARATION BY INTERMEDIARY/PROPOSER

I, the intermediary/ proposer hereby declare and confirm that I have explained/understood the features, terms and conditions of the policy and questions contained in the proposal form. I have also explained/understood that the answers to the questions contained in the proposal form, forms the basis of the contract of insurance. If any information/statement given in proposal is found to be untrue, the policy shall be treated as void ab intio and the premium paid shall be forfeited to the Company.

IMD name: **Proposer name:**
IMD Code: **Proposer sign:**

IMD Sign*:
*Stamp in case of Company

DECLARATION IN CASE THE PROPOSER IS ILLITERATE OR PROPOSAL FORM IS IN LANGUAGE OTHER THAN UNDERSTOOD BY PROPOSER

(To be signed by person who has explained the contents of the proposal form to the Proposer)
I, the declarant/proposer hereby declare and confirm that I have explained/understood the contents of the proposal form in _____ language understood by proposer/me and proposer have affixed his/her signature/thumb impression on the proposal form only after understanding the contents thereof.

Declarant's Name:
Signature:

Proposer Name:
Signature/thumb impression

Prohibition of Rebates as per Section 41 of the Insurance Act 1938 (4 of 1938)`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 prospectus or tables of the insurer'.

Any person making default in complying with the provisions of this section shall be punishable with fine which may extend to ten lakh rupees.

9. For Office Use Only

Intermediary Name:	**Intermediary Code:**
Sales Manager Name:	**Sales Manager Code:**

10. Acknowledgement

Application No: | | | | | | | | | | |

Date: | d | D | m | M | y | Y | y | y |

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

Please note that this is only an acknowledgement receipt and does not amount to acceptance of risk or commencement of Policy. The Company will have no liability until the proposal is accepted by the Company and communicated so to the proposer and on receipt of full premium against the proposal. Acceptance of proposal and issuance of policy shall be subject to receipt of completed filled in and signed proposal form, premium payment and underwriting decision of the Company.

Signature of the receiver & office Seal:

Liberty General Insurance Limited
Registered Office: Unit 1501&1502, 15th Floor, Tower 2, One International Center, Senapati Bapat Marg, Prabhadevi, Mumbai – 400013,
Phone: +91 226700 1313 Fax: +91 226700 1606

ANNEXURE 'A'

Name	Contact No.	Email Address	Occupation	Loan Account no.	DOB	Gender	Nationality	Relationship with Primary Insured	Sum Insured	Pre-existing Disease	Height (cm)	Weight (kg)	Loan Amount	Purpose of Loan	Annual Income	Loan Tenure	EMI Amount	PAN No.	Nominee / Assignee Name	Relationship with Nominee / Assignee

Medical and Lifestyle related Information:

Name	Loan Account no.	DOB	Gender	Suffering /suffered from any disease / illness / Injury	Suffering/ suffered/treated for any heart related ailment / blood pressure / Diabetes / Cancer	Suffering/ suffered from Paralysis / Asthma / Epilepsy	Any present/past history of surgery/medication/ disability/ medical condition	Consumption of Alcohol / Smoke / Pan Masala / others	If answer to any questions is Yes, please elaborate				
									Name of illness / injury suffering from or suffered in the past	Date of first diagnosed / detected	Treatment / medication received / receiving	Details of Hospitalization (If any)	Is it fully cured
				Yes ☐ No☐	Yes ☐ No☐	Yes ☐ No☐	Yes ☐ No☐	Yes ☐ No☐					