LIC
भारतीय जीवन बीमा निगम
LIFE INSURANCE CORPORATION OF INDIA

Form No. HI/PPL/1

PROPOSAL FORM FOR LIC's HEALTH PLUS POLICY – PLAN 901

- IN UNIT-LINKED POLICIES, THE INVESTMENT RISK IN INVESTMENT PORTFOLIO IS BORNE BY THE POLICYHOLDER.
- LIC's Health Plus is a ULIP plan which is different from the traditional policies in the sense that it is subject to market risks.
- LIC does not authorize its agents/intermediaries, staff and officials to express their opinion on the future performance of the "ULIP" fund, excepting the prescribed illustrative rate of 6% and 10% growth.

Branch Office ▶		Division ▶	

.....FOR OFFICE USE ONLY.....

Proposal No.:		Inward No.:	
Rural/Urban		Date of receipt of proposal:	
First/Subsequent		Agent's Name & Code No.:	
Total Sum Assured		Licence No. & Date of expiry:	
BOC/Transaction No. Date		Dev. Officer's Name & Code	

Underwriter's Decision	Policy No. allotted

ALL ANSWERS ARE TO BE FILLED IN BLOCK LETTERS. ANSWERS MUST BE GIVEN IN WORDS.
STROKES OF PEN OR DOTS WILL NOT BE ACCEPTED AS REPLIES.

Amount Paid		Cheque/DD No.	
Cash		Drawn on (City/Town)	
		Name of the Bank	

A. PERSONAL DETAILS

Full Name of the proposer (Please attach proof of identity)		
Father's Full Name		
Address for Communication (Please attach proof of residence)		Pin code
Permanent Address		Pin code

Nationality		Qualification		Present Occupation	
Email id		Income Source		Employer's Name	
Tel. No. (Off)		Annual Income		Place of Service	
Tel. No.(Res)		'PAN' Number		Length of Service	
Mobile Phone		Income Tax Assessee	(Yes / No)	Exact Nature of Duties	

B. NOMINEE DETAILS

Full Name	
Age	
Relationship to the proposer	

If Nominee is a minor, furnish the following:

Appointee's Name	
Address	
Signature of Appointee	

C. DETAILS OF ALL MEMBERS TO BE INSURED (INCLUDING THE PRINCIPAL INSURED)

Insured Member's Name	Relationship to the Proposer	Sex	Age	DOB	Age proof	Initial Daily Cash Benefit

Note Please check the product features for conditions regarding inclusion of family members.
Please submit a separate form (Annexure I) duly filled and signed by the member who is to be included as a beneficiary.
If the member to be included is a minor, please submit a separate form (Annexure II) duly signed by the proposer on behalf of the minor.

D. ADDITIONAL PARTICULARS FOR CONSIDERATION OF THE PROPOSAL				
Plan	**Mode**	**No. of lives to be covered**	**Installment Premium**	**Additional Premium**

E. HEALTH DETAILS AND MEDICAL INFORMATION

Height ▸	**cms**	**Weight ▸**	**kgs**

1.	Do you smoke or consume any form of tobacco and /or alcohol?	☐ Yes ☐ No
2.	Are you currently taking any medication or drugs, either prescribed or not prescribed by a doctor, or have you suffered from any illness, disorder, disability or injury during the past 5 years which has required any form of medical or specialized examination (including X-ray, gynaecological investigations, pap smear, or blood tests), consultation, hospitalization or surgery?	☐ Yes ☐ No
3.	Do you have any proposal for life, medical, health, accident, disability cover, critical illness or any other health-related insurance that has been postponed, declined or accepted on special terms?	☐ Yes ☐ No
4.	Do you have a parent and /or a brother or a sister who has suffered/suffering from, or died under the age of 60 due to any of the following conditions: Heart disease, diabetes, stroke, hypertension, raised cholesterol, cancer, or any hereditary disease?	☐ Yes ☐ No
5.	Do you have any surgery planned or are you currently aware of any medical condition that might require medical advice/surgery in the near future?	☐ Yes ☐ No
6.	Have you suffered/suffering from any of the following:	
	a) Hypertension or High blood pressure	☐ Yes ☐ No
	b) Diabetes	☐ Yes ☐ No
	c) Cardiovascular disease e.g.: Palpitations, heart attack, Stroke, chest pain	☐ Yes ☐ No
	d) Genitourinary disease e.g.: Kidney disorder, Bladder disorder, urine abnormality, renal stones or genital organ disorder.	☐ Yes ☐ No
	e) Cancer of any type e.g.:Leukaemia (blood cancer), cyst or growth of any kind	☐ Yes ☐ No
	f) Mental disorder e.g.: Depression, anxiety, schizophrenia or any other mental or nervous disorder.	☐ Yes ☐ No
	g) Endocrine diseases e.g.: Thyroid or any other hormonal disorder	☐ Yes ☐ No
	h) Digestive disease e.g.: Liver and gall bladder disorder, gastric ulcer, bleeding from intestine or any other disorder of the digestive tract	☐ Yes ☐ No
	i) Respiratory diseases e.g.: Asthma, pneumonia, bronchitis, tuberculosis, persistent cough, or any other disorder of the chest or lungs.	☐ Yes ☐ No
	j) Musculoskeletal diseases e.g.: prolapsed disc, back or neck complaint, any physical disability or other disorder of the bones, joints, arthritis, gout etc	☐ Yes ☐ No
	k) Neurological diseases e.g.: Fits, epilepsy, recurrent headache, paralysis, any other disease or disorder of the brain, spinal cord or nerves.	☐ Yes ☐ No
	l) Congenital disorders	☐ Yes ☐ No
	m) Anaemia, hemophilia, thalassemia or any other disorders of the blood	☐ Yes ☐ No
7.	Have you ever been tested positive for HIV / AIDS, hepatitis B or C or sexually transmitted diseases?	☐ Yes ☐ No
8.	Have you been absent from work for more than 5 continuous days in the last two years due to health reasons?	☐ Yes ☐ No
9.	Have you ever been involved or planning to be involved in a dangerous sport or hobby? e.g.: diving, mountaineering, parachuting, private aviation, racing, etc.	☐ Yes ☐ No
10.	Are you currently covered under any health insurance policy with LIC or any other company?	☐ Yes ☐ No
11.	Whether any Proposal submitted and is pending in any of the LIC Offices ?	☐ Yes ☐ No

If the answer to any of the above questions (from 1-9) is "yes" please give details (such as units consumed, diagnosis and further information as cured, still under treatment, treatment from / to, copies of hospital/ diagnostic reports, reasons, details of declined/rejected/cancelled proposals etc) hereunder. Please attach separate sheet if necessary. For question numbers 10 & 11, if the answer is " yes ", please submit details in a separate sheet.

F. ADDITIONAL QUESTIONNAIRE FOR FEMALE LIVES

Are you pregnant now?	Date of last Delivery	Have you ever had any abortion or mis-carriage or caesarian section? **If so give details in a separate sheet.**	Date of last Menstruation
Husband's Full Name		His Occupation	His Annual Income

G. ADDITIONAL QUESTIONS IN THE CASE OF SERVICES IN ARMED FORCES

Wing to which you belong	Rank therein	Date of last Medical Examination	Medical category after Medical Examination	Were you ever below A-1 category If so when

H. INVESTMENT PATTERN OF THE FUND

FUND TYPE	Investments in Govt./Govt. Guaranteed securities/ corporate debt	Short-term investments such as Money Market instruments (incl. govt. securities and corporate debt)	Investment in listed equity shares	Details and objective of the fund for risk/return
Health Plus Fund	Not less than 50%	Not more than 90%	Not less than 10% & Not more than 50%	Income and Growth – Low Risk

I. ADDITIONAL QUESTIONS TO BE ANSWERED BY THE PROPOSER

a. Whether the terms and conditions of the proposed plan have been explained to you by the agent	☐ Yes ☐ No
b. Have you understood fully, the terms and conditions of the plan you propose to take	☐ Yes ☐ No

DECLARATION BY PROPOSER

I _____, hereby declare that I have read the proposal form fully and the same was interpreted to me by the agent and also declare that I have understood the nature of the questions and the importance of disclosing all material information while answering such questions. I hereby declare that the foregoing statements and answers to all questions, including those in the annexures signed by me, have been given by me after fully understanding the questions and the same are true and complete in every particular and that I have not withheld any information and I do hereby agree and declare that these statements and this declaration shall be the basis of the contract of assurance between me and the Life Insurance Corporation and that if any untrue averment be contained therein, the said contract shall be absolutely null and void and all monies which shall have been paid in respect thereof shall stand forfeited to the Corporation. Not withstanding the provision of any law, usage, custom or convention for the time being in force prohibiting any doctor/ hospital and / or employer from divulging any knowledge or information about me concerning my health or employment on the grounds of secrecy, I / my heirs, executors, administrators and assignees or any other person or persons having interest of any kind whatsoever in the policy contract issued to me hereby agree that such authority having such knowledge or information shall at anytime be at liberty to divulge any such knowledge or information to the Corporation and its representatives (including but not limited to Third Party Administrators).

And I further agree that, if after the date of submission of the proposal but before the issue of the first Premium Receipt (i) any change in the state of my health or my occupation or any adverse circumstances connected with my financial position or (ii) if a proposal for an assurance or application for revival of policy on my life made to any office of the Corporation or with any other insurer is withdrawn or dropped, deferred or accepted at increased premium or subject to a lien or on terms other than as proposed, I shall forthwith intimate the same to the Corporation in writing to reconsider the terms of acceptance of assurance. Any omission on my part to do so shall render this Assurance invalid and all moneys, which shall have been paid in respect thereof, shall stand forfeited to the Corporation. I hereby give my consent for undergoing medical examination/tests including test for HIV as required by Corporation. I further declare that I have discussed my financial standing with the agent/ intermediary. I confirm that I have been informed about and have understood the benefits and exclusions under this product for which I have made this application. In consultation with the agent/ intermediary, I have taken a personal and independent decision in an informed manner to go for the Plan. I understand that the "application money" deposited by me as a token consideration under this proposal for insurance, and the closing NAV on the date of completion of this proposal only will be applied for allotment of units.

Dated at_____on the _____day of_____200

Signature of witness _____
Name and address _____
_____

Signature or Thumb Impression of the proposer : _____

In case form is filled up / signed in a language different from that of the Proposal Form:

Declaration by the person filling in the form: "I hereby declare that I have fully explained the above questions to the proposer in _____ language and I have truthfully recorded the answers given by the proposer."

Name &Address of the Declarant: _____

Signature of the declarant : _____

Declaration by the Proposer:

"I certify that the contents of the form and documents have been fully explained to me by Mr/ Ms:_____ and I have understood the significance of the proposed contract."

Signature or Thumb impression of the Proposer:_____

In case the Proposer is illiterate, the thumb impressions of the Proposer should be attested by a person of standing whose identity can easily be established, but unconnected with the Corporation and this declaration should be made by him/her.

"I hereby declare that I have fully explained the above questions and contents of the proposal form to the proposer in _____language, and that the proposer has affixed his / her thumb impression above, in my presence, after fully understanding the contents thereof."

Name & Address of the Declarant: _____

Signature of the attester and Declarant : _____

FOR MEDICAL CASES ONLY

I certify that the proposer has signed / put his / her thumb impression in my presence after admitting that all answers to questions under "Section E" in this proposal form are properly recorded.

_____
Signature or Thumb Impression of the Proposer

_____
Signature of the Medical Examiner

RELEVANT PROVISIONS UNDER INSURANCE ACT 1938

SECTION 41 – PROHIBITION OF REBATES

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 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. Provided that acceptance by an insurance agent of commission in connection with a policy of life insurance taken out by himself on his own life shall not be deemed to be an 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.

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

SECTION 45 – INDISPUTABILITY CLAUSE

No policy of Life Insurance shall, after the expiry of two years from the date on which it was effected, be called in question by an Insurer on the ground that a statement made in the proposal for insurance or any report of a medical officer or referee or friend of the Insurer or in any other document leading to the issue of the Policy, was inaccurate or false, unless the insurer shows such statement was on material matter or suppressed facts which it was material to disclose and that it was fraudulently made by the policy holder and that the policy holder knew at the time of making it that the statement was false or that it suppressed facts which it was material to disclose.

Note: "Material" shall mean and include all important, essential and relevant information in the context of underwriting the risk to be covered by the Corporation.

Check List

Please verify the following items under this checklist before submitting the proposal form to LIC office.

S. No	Title	Please Tick Yes or No ✓	
1	Photo Addendum sheet (Form No. HI/PPL/1/a) with photos of members to be covered under Health Insurance Policy (Photos to be pasted as per instructions on the addendum)	☐ YES	☐ NO
2	Bank details addendum sheet (Form No. HI/PPL/1/b)	☐ YES	☐ NO
3	Cancelled cheque of the policyholder (to be pasted on the addendum sheet)	☐ YES	☐ NO
4	Addition (Annexure I & II)	☐ YES	☐ NO
5	Standard Age Proof of the proposer (Date of Birth Certificate)	☐ YES	☐ NO
6	Standard Age Proof of the Members separately for each member	☐ YES	☐ NO
7	Full details of the health policies held on the life of the proposer in a separate sheet (If space provided in the proposal is not sufficient)	☐ YES	☐ NO
8	Full details of the Health and medical information on the lives of the proposer and members on a separate sheet (if the space provided is not sufficient)	☐ YES	☐ NO
9	Medical reports / Special reports of the proposer and members separately	☐ YES	☐ NO
10	Consideration amount towards First premium	☐ YES	☐ NO
11	Proof of Residence (Telephone bill, Ration Card, Electricity bill, Bank A/c Statement, Letter from any recognized public authority)	☐ YES	☐ NO
12	Proof of Identity (Pass port, Pan card, Driving License, Voter's Identity, letter from a recognized public authority verifying the identity and residence proof of the proposer)		
13	**Income Proof (Standard) (Any of the following)**		
	IT Assessment orders /IT Returns,	☐ YES	☐ NO
	Employer's Certificate,	☐ YES	☐ NO
	Audited Company Accounts	☐ YES	☐ NO
	Audited Firm accounts	☐ YES	☐ NO
	Partnership deed	☐ YES	☐ NO
	Income Proof (Non Standard) (Any of the following)		
	Chartered Accountant's Certificate	☐ YES	☐ NO
	Agricultural Income Certificate	☐ YES	☐ NO
	Agricultural land details & Income assessments	☐ YES	☐ NO
	Bank Cash flow statements and pass book	☐ YES	☐ NO
	(The list is only illustrative and not exhaustive)		
14	Whether declarations have been signed at all places and duly witnessed	☐ YES	☐ NO
15	Whether Details and signature of appointee are taken in case of nominee being minor	☐ YES	☐ NO
16	Whether all fields are properly filled in (without any blanks or dashes)	☐ YES	☐ NO
17	Whether corrections if any in the proposal form are authenticated by the proposer	☐ YES	☐ NO

Medical Requirements

Major Surgical Benefit Sum Assured	Age Nearest Birthday (yrs)			
	Up to 35	36 – 40	41 – 50	51 - 55
50,000 to 1,00,000	NM	NM	NM	A
1,00,001 to 2,00,000	NM	NM	A	B
2,00,001 to 3,00,000	NM	A	A	B
3,00,001 to 5,00,000	A	B	B	C

Where **A** – MER, FBS, RUA; **B** – MER, FBS, RUA, HbA1c, ECG ; **C** – MER, FBS, RUA, HbA1c, TMT

Note: The above requirements are mandatory. In addition, if any other Medical/ Special reports are called for by the underwriter, they will have to be furnished.

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LIFE INSURANCE CORPORATION OF INDIA

HI/ACR/1

AGENT'S CONFIDENTIAL REPORT/MORAL HAZARD REPORT

Agent's Name		Club Membership	License No.	Date of expiry	Branch Code
Agent's Code	D.O. Code				
Name of Life Proposed		Age	Occupation		
			Nature of duties		

1. (a) Acquaintance with the proposer (No. of Years):

(b) Relationship with the proposer :

(c) Educational qualification of the Proposer :

2. (i) Income of the proposer from :	Amount per annum	Remarks
(a) Employment		
(b) Business / Profession		
(c) HUF		
(d) Agricultural Income		
(e) Income from other sources		
Total		

(ii) Proof of income verified in respect of income stated above

(a) Salary sheet or certificate issued by the Employer :

(b) Certificate issued by the C.A.(copies of IT returns enclosed) :

(c) PAN / GIR No. of the proposer :

3. Physical Measurements and Identification Marks of the Proposer and other Members (beneficiaries) to be insured under the proposal.

	Name	Height (Cms)	Weight (kgs)	Abdomen (Cms)	Chest(Cms) Exp	Chest(Cms) Insp.	Identification Marks	
PROPOSER							1	
							2	
MEMBER 1							1	
							2	
MEMBER 2							1	
							2	
MEMBER 3							1	
							2	
MEMBER 4							1	
							2	

4. Declaration by the Agent

I hereby declare that I have discussed the following aspects with the proposer/ members covered and the statements recorded by me reflect the true answers and correct statements and bear testimony to the replies given by the proposer/members covered:

I. I am personally satisfied that, the proposer is financially sound and that his income justifies the current proposal.

II. I have personally seen the proposer/members covered and satisfied that he/ she does not have any physical deformity or impaired sight or hearing problem or any mental retardation.

III. My inquiries regarding the health condition of the proposer/members covered do not reveal that the proposer/members covered has suffered from any illness or has been investigated or hospitalized or has undergone any surgical procedure or operation.

IV. I confirm that general state of health of proposer/members covered is good.

V. I have discussed with the proposer/members covered about the status of all his / their previous health policies and that no policy has lapsed during the last 5 years and all his / their policies are in force.

VI. I have discussed and I am aware that no proposal or revival of policy on the life of the proposer/members covered has been deferred, declined or dropped or accepted at terms other than those proposed.

VII. I have also personally discussed about the occupation, financial and social status of the proposer/members covered and I am aware that neither these nor any other circumstances will add to the risk.

VIII. I have fully explained the terms and conditions of the health insurance plan to the proposer / beneficiary.

I further declare that the foregoing statements are true and correct to the best of my knowledge.

Dated at _____ **on the** _____ **day of** _____ **200**

Agent's Name and address _____

_____

Phone Number _____ **Signature of the Agent**

(To be completed by Dev. Officer)

I am satisfied with the identity of the proposer/ members covered and on the basis of my independent enquiries, I hereby declare that the foregoing statements are true and correct to the best of my knowledge and belief

Dated at _____ **on the** _____ **day of** _____ **200**

Signature

Name

Designation

(To be completed by ABM(s)/B. M./Sr. B.M./Chief Mgr)

I am satisfied with the identity of the proposer/ members covered and on the basis of my independent enquiries, I hereby declare that the foregoing statements are true and correct to the best of my knowledge and belief

Dated at _____ **on the** _____ **day of** _____ **200**

Signature

Name

Designation

LIC
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LIFE INSURANCE CORPORATION OF INDIA

Life Insurance Corporation of India
Health Plus Plan Proposal Form – Addendum for Bank Details

HI/PPL/1/b

Name of the Proposer		
Bank Details of Proposer	Bank Name	
	Bank Branch location & Code	
	Bank Account Number	
	NEFT / RTGS **IFSC**- CODE NUMBER	
	MICR No	

Note: I undertake to intimate regarding change in bank details to LIC promptly and I am aware that claims arising under this Policy will be settled through the above Bank Account only.

Signature of the Proposer

Affix a cancelled cheque / Xerox copy of cheque here

To be filled by Divisional Health Unit

The payments will be made based on the accuracy of the above data. Divisional Health Unit is requested to verify data in Policy master and ensure accuracy of data.

Policy Number	Division Name & Code	Branch Name & Code

The **Bank Account Details** are verified with the data captured in the Policy Master and are found to be in order and where discrepancies have been noticed the data has been corrected.

Prepared by **Checked by** **Manager (Health Insurance)**

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LIFE INSURANCE CORPORATION OF INDIA

Life Insurance Corporation of India

Health Plus Plan Proposal Form – Photo Addendum for preparation of Identity Cards

Name of the Proposer	

	Proposer	Spouse/ Member 1	Member 2	Member 3	Member 4
	Affix Stamp size photo only	Affix Stamp size photo only	Affix Stamp size photo only	Affix Stamp size photo only	Affix Stamp size photo only
Name					
DOB					
Gender					
Relation to proposer					

Signature of the Proposer	

To be filled in by Divisional Office Health Unit

Policy Number	Division Name & Code	Branch Name & Code	Sent to TPA on

Prepared By Checked by Manager (Health Insurance)

IMPORTANT: Form to be detached and sent to the TPA for the issue of Health Card