

## NAVI HEALTH SEASONAL BYTE – PROPOSAL FORM

**Proposal Form Number:**

**URN: NAVIGICSB1018V0**

### GUIDELINES OF FILLING THIS PROPOSAL FORM

- 1) Please complete all sections in capitals and tick the boxes wherever applicable. Please furnish all information that is sought and is having a bearing on the risk.
- 2) Failure to disclose facts material to the assessment of the risk or providing misleading Information may render the contract void.
- 3) We shall process the proposal within a reasonable period but not exceeding 15 days from the date of receipt of proposal or any other requirement called by us.
- 4) Where a proposal deposit is refundable under any circumstances, we shall refund the same within 15 days from the date of underwriting decision on the proposal.
- 5) This Proposal Form shall be the basis of contract for Policy issuance and shall be signed by the Proposer.
- 6) We are under no obligation to accept any proposal for insurance. Our liability will commence only when this Proposal is accepted by Us (subject to the policy terms and conditions) and the premium is received and realised.

### I. PROPOSER DETAILS

Proposer Name	: <input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms.								
Date of Birth	: <table border="1" style="display: inline-table; border-collapse: collapse;"><tr><td style="width: 20px; text-align: center;">D</td><td style="width: 20px; text-align: center;">D</td><td style="width: 20px; text-align: center;">M</td><td style="width: 20px; text-align: center;">M</td><td style="width: 20px; text-align: center;">Y</td><td style="width: 20px; text-align: center;">Y</td></tr></table>	D	D	M	M	Y	Y	Marital Status	: <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Others
D	D	M	M	Y	Y				
Gender	: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender	E-mail Id	: _____						
Occupation	: <input type="checkbox"/> Student <input type="checkbox"/> Self Employed <input type="checkbox"/> Salaried <input type="checkbox"/> House Wife <input type="checkbox"/> Retired <input type="checkbox"/> Others (please specify) : _____								
Aadhar Number	: _____								
PAN Number	: _____								
SEZ Holder	: <input type="checkbox"/> Yes <input type="checkbox"/> No	GSTIN	: _____						
Address	: _____								
(Note - This address shall be taken for GST Computation)	Landmark : _____	City / Town	: _____						
	District : _____	Pin Code	: _____						
	Telephone : _____	Mobile No.	: _____						
<input type="checkbox"/> I hereby consent that the Policy Documents shall be sent to me by e-mail only on my registered e-mail Id. I understand that this authorisation can be revoked by me at the time of renewal by contacting your branch office personally or customer care by writing a mail/ calling your toll-free number.									

### II. POLICY DETAILS – Please select the required Sum Insured & Type of Policy

<b>Type of Plan</b>	Indemnity <input type="checkbox"/> Benefit <input type="checkbox"/>								
<b>Sum Insured</b>	<b>Indemnity Plan</b> - ₹ 2,500 <input type="checkbox"/> ₹ 5,000 <input type="checkbox"/> ₹ 10,000 <input type="checkbox"/> ₹ 25,000 <input type="checkbox"/> ₹ 50,000 <input type="checkbox"/> ₹ 75,000 <input type="checkbox"/> ₹ 1 Lac <input type="checkbox"/> ₹ 2 Lac <input type="checkbox"/>								
	<b>Benefit Plan</b> - ₹ 2,500 <input type="checkbox"/> ₹ 5,000 <input type="checkbox"/> ₹ 7,500 <input type="checkbox"/> ₹ 10,000 <input type="checkbox"/>								
<b>Proposed Policy Period</b>	From: <table border="1" style="display: inline-table; border-collapse: collapse;"><tr><td style="width: 20px; text-align: center;">D</td><td style="width: 20px; text-align: center;">D</td><td style="width: 20px; text-align: center;">M</td><td style="width: 20px; text-align: center;">M</td><td style="width: 20px; text-align: center;">Y</td><td style="width: 20px; text-align: center;">Y</td></tr></table>	D	D	M	M	Y	Y	Policy Tenure	<input type="checkbox"/> 1 Year <input type="checkbox"/> 2 Year <input type="checkbox"/> 3 Year
D	D	M	M	Y	Y				
<b>Policy Type</b>	<input type="checkbox"/> Individual <input type="checkbox"/> Family Floater#								
# In case of Family Floater Policy -Sum Insured will be floating among the family members.		<b>NOTE</b> – Please note that your Policy period will start from the date of receipt of premium to Us.							

### III. PROPOSED INSURED DETAILS

S. No.	Name	Gender	Date of Birth	Marital Status	Occupation	Are you PEP *	Relationship with Proposer	SI Opted	Pan Card Number
1		M / F	DD/MM/YYYY			Yes/No			
2		M / F	DD/MM/YYYY			Yes/No			
3		M / F	DD/MM/YYYY			Yes/No			
4		M / F	DD/MM/YYYY			Yes/No			
5		M / F	DD/MM/YYYY			Yes/No			

**\*Confirmation is required if the proposed member or family member or close relative is a Politically Exposed Person**

**PEP** means Politically Exposed Persons. These are individuals who are or have been entrusted with prominent public functions i.e. Heads / Ministers of Central or State Government, Senior Politicians, Senior Government, Judicial or Military officials, Senior Executives of Government companies, important party officials. (If you are PEP OR having any court cases or litigation or legal charges, kindly fill the separate PEP questionnaire Form.)

### IV. NOMINEE DETAILS

In the event of the death of the Policyholder, any payment due under the Policy shall become payable to the Nominee in accordance with the Policy terms and conditions. The nominee must be an immediate relative of the Proposer. Nominee for persons proposed to be insured shall be the Proposer himself/herself.

Nominee Name	Date of Birth	Relationship with Proposer	Address of the Nominee

If Nominee is minor, please give the name and address of the appointee and relationship with the minor

Appointee Name	Date of Birth	Relationship with Minor	Address of the Appointee

### V. MEDICAL AND HEALTH INFORMATION

Please answer below mentioned questions		Insured 1	Insured 2	Insured 3	Insured 4	Insured 5
1.	Are you currently suffering or taking any treatment for Fever or been diagnosed with Dengue/Chikungunya/Malaria/Leptospirosis/Swine Flu/Encephalitis/Zika fever in past 15 days?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

**Note - In case of additional members and there is insufficient to provide health information, please attach extra sheet duly signed.)**

### VI. CURRENT/PREVIOUS INSURANCE POLICY DETAILS

Are You insured under any Health Insurance Policy? If yes, Please provide the below details.

Insured Name	Policy Number	Insurer Name	Policy Period		Sum Insured	Claim Lodged (if any)	Cumulative Bonus
			From	To			
			DD/MM/YY	DD/MM/YY			
			DD/MM/YY	DD/MM/YY			
			DD/MM/YY	DD/MM/YY			
			DD/MM/YY	DD/MM/YY			
			DD/MM/YY	DD/MM/YY			

Are you applying for portability?  Yes  No (If Yes, portability form to be completed and attached)

Do you have any other Navi GI Insurance Policy?  Yes  No

If Yes, please mention the Policy Number to avail discount in premium - \_\_\_\_\_

### VII. PREMIUM PAYMENT AND BANK DETAILS

For Cheque/DD/PO (Payable in favour of NAVI General Insurance Company Limited)

Payment Option:      Cheque                            Demand Draft            Fund Transfer            Pay Order        
                                  Debit Card                            Credit Card                     

Premium Amount:      ₹ \_\_\_\_\_                      Amount in Words:      \_\_\_\_\_

As per the Regulatory requirements, we can affect payment of the refund (if any) and or claims only through Electronic Clearing System (ECS) / National Electronic Funds Transfer (NEFT) / Real Time Gross Settlement (RTGS) / Interbank Mobile Payment Service (IMPS). For this purpose, please submit the following details of the Proposer's bank account.

Account Holder Name      :      \_\_\_\_\_

Instrument Number      :      \_\_\_\_\_                      Instrument Date      :      \_\_\_\_\_

Instrument Amount      :      \_\_\_\_\_                      Bank Name      :      \_\_\_\_\_

Credit/Debit Card No.      :      \_\_\_\_\_                      Expiry Date      :      \_\_\_\_\_

Account No.      :      \_\_\_\_\_                      IFSC/MICR Code      :      \_\_\_\_\_

UPI ID      :      \_\_\_\_\_

Type of Account      :      Saving Bank's Account            Current Account        
                                  Others (Please Specify)     

Note - If the Premium cheque is not paid from the above-mentioned account then a cancelled cheque leaf of the above-mentioned account is to be attached.

### VIII. ELECTRONIC INSURANCE ACCOUNT DETAILS OF PROPOSER

(Email Id is mandatory)

Do you have an EIA      :       Yes       No                      If No, do you wish to apply for EIA      :       Yes       No

If Yes, please quote the EIA number      :      <<\_\_\_\_\_>>

If applied, please mention your preferred Insurance Repository      :      <<\_\_\_\_\_>>

Email Id (Registered with Insurance Repository)      :      <<\_\_\_\_\_>>

Your Policy will be credited in your EIA account and your address details as mentioned in the EIA shall override the address provided in this proposal for Insurance. We request you to inform the Repository of any changes in the details immediately.

### IX. DECLARATION

- 1) 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 authorised to propose on behalf of these other persons.
- 2) 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.
- 3) 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.
- 4) 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.
- 5) 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: \_\_\_\_\_ Place: \_\_\_\_\_ Signature of Proposer \_\_\_\_\_

X. OTHER DECLARATIONS	
<input type="checkbox"/>	Any GST liability and payment for the same is dependent on the details (viz GSTIN, address, zero-rating entitlement etc) provided by me. Navi General Insurance Limited will rely on such information for the purpose of compliance with applicable GST regulations and shall not be under obligation to evaluate authenticity/accuracy of the same. Further, in case any GST liability (in terms of tax, interest, penalty and associated litigation cost) arises on Navi General Insurance Limited on account of any incorrect/ incomplete/ non-compliance on behalf of me. I will be immediately liable to pay the same on notification by Navi General Insurance Limited. The said liability shall vest irrespective of the completion of the insurance period covered within the policy contract.
<input type="checkbox"/>	I hereby consent to and authorize Navi General Insurance Limited to make welcome calls, service calls or any other communication (electronic or otherwise) with respect to the existing policy of the Company from time to time.
<input type="checkbox"/>	I/We hereby confirm that all premiums have been/will be paid from bonafide sources and no premiums have been/will be paid out of proceeds of crime related to any of the offence listed in Prevention of Money Laundering Act, 2002. I understand that the Company has the right to call for documents to establish sources of funds. The insurance company has right to cancel the insurance contract in case I am/have been found guilty by any competent court of law under any of the statutes, directly or indirectly governing the prevention of money laundering in India.

XI. VERNACULAR DECLARATION	
I hereby declare that, I have fully explained the contents of the Proposal Form and terms and conditions of the Policy to the Proposer in the language understood to him/her.	
Signature/Thumb Impression of the Proposer: _____	
Name of Witness: _____	Signature of Witness: _____
Date: _____	Place: _____

XII. INTERMEDIARY DECLARATION	
I, _____ (Full Name), in my capacity as an Insurance Advisor/ Specified Person of the Corporate Agent/Authorized employee of the Broker/Relationship Officer, do hereby declare that I have explained all the contents of this Proposal Form, including the nature of the questions contained in this Proposal Form to the Proposer including statement(s), information and response(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, the Company shall have the right to vary the benefits which may be payable and further more 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 premiums paid under the Policy may be forfeited to the company.	
License No./ID (Advisor / Corporate Agent / Broker / Relationship Officer) : _____	
Date: _____	Place: _____ Signature of Agent: _____

Prohibition of Rebates: Section 41 of the Insurance Act, 1938 (and amendments thereof)	
1)	No person shall allow or offer to allow, either directly or indirectly, as an inducement to any person to take out 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 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 prospectus or tables of the insurers.
2)	Any person making default in complying with the provisions of this section shall be liable for penalty which may extend to ten lakh rupees.

INTERMEDIARY DETAILS (FOR OFFICE USE ONLY)			
Branch Office	:	Intermediary Code	:
Branch Code	:	Intermediary Name	:
Business Sector	:	Intermediary contact Number	:
		Urban/Rural/Social	

**ACKNOWLEDGE SLIP**

Proposal form received from: Mr./Mrs./Ms	
Address: _____	Premium amount: ₹ _____ To be debited from
Account of Mr./Ms _____	Account Number: _____ Bank Name: _____
Cheque Number: _____	Date: _____ Branch: _____

Navi Health Seasonal Byte | UIN: NAVHLIP22059V032122

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CIN: U66000KA2016PLC148551 | IRDAI Registration Number: 155