

Proposal Form for Reliance Travel Care Policy

Individual/Family/Senior Citizens/Asia/Students/Schengen/Annual

Proposal Form No: _____

- To be filled and signed by proposer
- This proposal shall be the basis of contract for Policy issuance.
- Reliance General Insurance Company Ltd. (the "Company") is under no obligation to accept any proposal for insurance. The liability of the Company commences only when this proposal is accepted by the Company and the premium is received. If the Company accepts a proposal for insurance, it shall be subject to the Policy Terms and Conditions.

Intermediary Details

Intermediary Name ☐ Mr. ☐ Mrs. ☐ Ms.

Intermediary Code

Branch Name

Branch Code

Sales Manager Name ☐ Mr. ☐ Mrs. ☐ Ms.

Sales Manager Code

Proposer Details

- Name of the Proposer** ☐ Mr. ☐ Mrs. ☐ Ms.
(IN CAPITAL LETTERS)
- Address (IN CAPITAL LETTERS)**
 Flat/Building Road/Street/Sector
 Area City
 Pin Code State Country
 Residence Number Mobile
 Gender Passport No.
 Pan card (Mandatory for premium above ₹ 50,000 and for Travel to Nepal / Bhutan)
 UID Aadhaar No. D.O.B
 Email Id Nationality
 Source of Funds ☐ Business ☐ Profession ☐ Salary ☐ Agricultural Income ☐ Savings ☐ Others
 Monthly Income ☐ Upto ₹ 20,000 ☐ ₹ 20,001 to ₹ 50,000 ☐ ₹ 50,001 to ₹ 1,00,000 ☐ ₹ 1,00,001 and above
- Do you have a GST Registration Number ☐ Yes ☐ No
 If Yes, please specify

Proposer's Bank Details

- Name of the Bank Account Holder ☐ Mr. ☐ Mrs. ☐ Ms.
- Bank Account No.:
- Account: ☐ Saving ☐ Current
- Name of the Bank
- Branch
- MICR Code (9 digit MICR code number of the bank and branch appearing on the cheque issued by the bank)
- IFSC Code (11 character code appearing on your cheque leaf)

☐ I understand that any refund due on the premium payment / any payment / claims to be directly credited to my aforesaid Bank Account.*

*As per IRDAI, its mandatory that all payments made to the insured are only through electronic mode.

Nomination Details

The nominee as declared hereunder shall become eligible for claim payment under the Policy as per the terms and conditions of the Policy, in the event of the death of the Policyholder. The receipt of proceeds by the nominee would be sufficient discharge to the Company. Nominee for all other person (s) proposed shall be the proposer himself/herself.

Name of Nominee	D.O.B	Relationship with Proposer	Address of Nominee
	dd/mm/yyyy		

An ISO 9001:2008 Certified Company

Details of person(s) proposed to be insured				
Section A : Personal Details				
Details		Member 1	Member 2*	Member 3*
Name	First name			
	Last name			
DOB		dd/mm/yyyy	dd/mm/yyyy	dd/mm/yyyy
Gender				
Passport No.				
Nationality				
Relationship with Proposer				

*Applicable in case of Family Plan

Has any person to be insured been diagnosed/hospitalized/under any treatment for any illness / disease or injury during any time in past?
If yes please select the disease / injury as mentioned below. If others, please specify

A. Diabetes (Not insulin based)	<input type="checkbox"/> Yes <input type="text" value="mm/yyyy"/>	<input type="checkbox"/> Yes <input type="text" value="mm/yyyy"/>	<input type="checkbox"/> Yes <input type="text" value="mm/yyyy"/>	<input type="checkbox"/> Yes <input type="text" value="mm/yyyy"/>
B. Hypertension	<input type="checkbox"/> Yes <input type="text" value="mm/yyyy"/>	<input type="checkbox"/> Yes <input type="text" value="mm/yyyy"/>	<input type="checkbox"/> Yes <input type="text" value="mm/yyyy"/>	<input type="checkbox"/> Yes <input type="text" value="mm/yyyy"/>
C. HIV/AIDS/STD	<input type="checkbox"/> Yes <input type="text" value="mm/yyyy"/>	<input type="checkbox"/> Yes <input type="text" value="mm/yyyy"/>	<input type="checkbox"/> Yes <input type="text" value="mm/yyyy"/>	<input type="checkbox"/> Yes <input type="text" value="mm/yyyy"/>
D. Liver disease(s)	<input type="checkbox"/> Yes <input type="text" value="mm/yyyy"/>	<input type="checkbox"/> Yes <input type="text" value="mm/yyyy"/>	<input type="checkbox"/> Yes <input type="text" value="mm/yyyy"/>	<input type="checkbox"/> Yes <input type="text" value="mm/yyyy"/>
E. Leukaemia / malignant tumour	<input type="checkbox"/> Yes <input type="text" value="mm/yyyy"/>	<input type="checkbox"/> Yes <input type="text" value="mm/yyyy"/>	<input type="checkbox"/> Yes <input type="text" value="mm/yyyy"/>	<input type="checkbox"/> Yes <input type="text" value="mm/yyyy"/>
F. Cardiac ailments	<input type="checkbox"/> Yes <input type="text" value="mm/yyyy"/>	<input type="checkbox"/> Yes <input type="text" value="mm/yyyy"/>	<input type="checkbox"/> Yes <input type="text" value="mm/yyyy"/>	<input type="checkbox"/> Yes <input type="text" value="mm/yyyy"/>
G. Arthritis / Joint pain	<input type="checkbox"/> Yes <input type="text" value="mm/yyyy"/>	<input type="checkbox"/> Yes <input type="text" value="mm/yyyy"/>	<input type="checkbox"/> Yes <input type="text" value="mm/yyyy"/>	<input type="checkbox"/> Yes <input type="text" value="mm/yyyy"/>
H. Kidney Disease(s)	<input type="checkbox"/> Yes <input type="text" value="mm/yyyy"/>	<input type="checkbox"/> Yes <input type="text" value="mm/yyyy"/>	<input type="checkbox"/> Yes <input type="text" value="mm/yyyy"/>	<input type="checkbox"/> Yes <input type="text" value="mm/yyyy"/>
I. Paralysis/Stroke	<input type="checkbox"/> Yes <input type="text" value="mm/yyyy"/>	<input type="checkbox"/> Yes <input type="text" value="mm/yyyy"/>	<input type="checkbox"/> Yes <input type="text" value="mm/yyyy"/>	<input type="checkbox"/> Yes <input type="text" value="mm/yyyy"/>
J. Congenital Disease(s)	<input type="checkbox"/> Yes <input type="text" value="mm/yyyy"/>	<input type="checkbox"/> Yes <input type="text" value="mm/yyyy"/>	<input type="checkbox"/> Yes <input type="text" value="mm/yyyy"/>	<input type="checkbox"/> Yes <input type="text" value="mm/yyyy"/>
K. Injury	<input type="checkbox"/> Yes <input type="text" value="mm/yyyy"/>	<input type="checkbox"/> Yes <input type="text" value="mm/yyyy"/>	<input type="checkbox"/> Yes <input type="text" value="mm/yyyy"/>	<input type="checkbox"/> Yes <input type="text" value="mm/yyyy"/>
L. Thalassemia	<input type="checkbox"/> Yes <input type="text" value="mm/yyyy"/>	<input type="checkbox"/> Yes <input type="text" value="mm/yyyy"/>	<input type="checkbox"/> Yes <input type="text" value="mm/yyyy"/>	<input type="checkbox"/> Yes <input type="text" value="mm/yyyy"/>
M. Obstetrics/Pregnancy	<input type="checkbox"/> Yes <input type="text" value="mm/yyyy"/>	<input type="checkbox"/> Yes <input type="text" value="mm/yyyy"/>	<input type="checkbox"/> Yes <input type="text" value="mm/yyyy"/>	<input type="checkbox"/> Yes <input type="text" value="mm/yyyy"/>
N. Neurological disorders	<input type="checkbox"/> Yes <input type="text" value="mm/yyyy"/>	<input type="checkbox"/> Yes <input type="text" value="mm/yyyy"/>	<input type="checkbox"/> Yes <input type="text" value="mm/yyyy"/>	<input type="checkbox"/> Yes <input type="text" value="mm/yyyy"/>
O. Others (Please specify) Name of Illness / Injury				
Since	<input type="text" value="mm/yyyy"/>	<input type="text" value="mm/yyyy"/>	<input type="text" value="mm/yyyy"/>	<input type="text" value="mm/yyyy"/>

P. Does any person proposed to be insured smoke or consume tobacco or alcohol? If yes, Please indicate	Yes / No	Yes / No	Yes / No	Yes / No
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Trip Details (Please select the plan of your choice)				
Individual	<input type="checkbox"/> Standard	<input type="checkbox"/> Silver	<input type="checkbox"/> Gold	<input type="checkbox"/> Platinum
Senior Citizens (61-70)	<input type="checkbox"/> Standard	<input type="checkbox"/> Silver	<input type="checkbox"/> Gold	<input type="checkbox"/> Platinum
Senior Citizens (71-80)	<input type="checkbox"/> USD 15,000(with Sublimit)		<input type="checkbox"/> USD 50,000 with Sublimit	<input type="checkbox"/> USD 50,000 without Sublimit)
(81-90)	<input type="checkbox"/> USD 50,000(with Sublimit)			
Family	<input type="checkbox"/> Standard	<input type="checkbox"/> Gold		
Asia	<input type="checkbox"/> Standard	<input type="checkbox"/> Silver		
Students	<input type="checkbox"/> Basic	<input type="checkbox"/> Standard	<input type="checkbox"/> Silver	<input type="checkbox"/> Gold <input type="checkbox"/> Platinum
Schengen	<input type="checkbox"/> Basic	<input type="checkbox"/> Standard		
Annual	<input type="checkbox"/> Standard	<input type="checkbox"/> Plus	<input type="checkbox"/> Elite	
Do you wish to opt for the add-on benefits under the Student Plan? (Applicable for Standard, Silver, Gold & Platinum Plan variants) <input type="checkbox"/> Yes <input type="checkbox"/> No				
If yes, do you also wish to opt for any of the following additional add-on benefits? (Applicable on a case to case basis & subject to underwriting approvals)				
<input type="checkbox"/> Chiropractic Treatment <input type="checkbox"/> Physiotherapy <input type="checkbox"/> Skilled nursing facility				
Purpose of visit: <input type="checkbox"/> Personal bussiness <input type="checkbox"/> Leisure <input type="checkbox"/> Study <input type="checkbox"/> Work <input type="checkbox"/> Employment				

Trip Type ☐ Multi ☐ Single
Trip Duration ☐ 30 ☐ 45 Days
Date of Journey Date Of Return
Are you visiting USA / Canada? ☐ Yes ☐ No Does the planned trip involve any kind of sporting activities or participation? ☐ Yes ☐ No
Countries that you are visiting

Home Details (Please fill in the following details, if the plan opted contains home burglary insurance cover)

Address of home to be covered in India under home burglary insurance

Student Details (Please fill in the following details, if student plan has been opted)

Name of the University
Address of the University
Phone Fax
Course Duration (in months) Tuition Fees for the course (per semester)
No. of semesters/trimesters Course Start Date
Name of the sponsor in India
Address of the sponsor
Phone Fax

Attending Physician's Details

Name of Family Physician: ☐ Mr. ☐ Mrs. ☐ Ms.
Contact Number Email Id

Premium Payment Details

Payment by: Cheque*/DD*/ Credit Card#/Debit Card # (Tick whichever is applicable)
☐ Cheque ☐ DD ☐ Credit Card ☐ Debit Card
Cheque or DD Amount /- Amount in words ()
Bank Name
Cheque No./DD No./Card No. Cheque/DD Date
Name of the Premium Payer

*In case of payment made through Cheque / DD then please issue an A/c payee instrument in favour of "Reliance General Insurance Company Limited" #In case of payment made through Credit/ Debit Card the Card needs to be in the name of the Proposer

Acknowledgement for Proposal

Please retain this counterfoil for your records (on behalf of Reliance General Insurance Company Limited)
NOT VALID AGAINST CASH Proposal Form No.
Date:
We acknowledge the receipt of payment of ₹ vide cheque/DD from
Mr./Mrs./Ms.
Please note that this is only an acknowledgement receipt and does not amount to acceptance of risk or commencement of Policy.
Reliance General Insurance Company Limited is not liable for any claim between the time that the proposal amount is received and
Policy start date. The validity of receipt is subject to realization of proposal amount. Acceptance of proposal and issuance of Policy
shall be subject to receipt of completed proposal form, premium payment, medical reports (wherever applicable) and underwriting
decision of the Company.
Name of the Employee:

Signature of the Employee:

Company Seal & Stamp

Declaration & Warranty on Behalf of All Persons Proposer to be Insured

- i. It is hereby declared that the person(s) (a) will not be traveling against the advice of a medical practitioner (b) are not on the waiting list for any medical treatment (c) are not travelling for the purpose of obtaining medical treatment (d) have not received a terminal prognosis for a medical condition before the journey
- ii. I have read and understood the brochure, prospectus, sales literature & Policy wordings and confirm to abide by the same.
- iii. 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 insurance company and that the policy will come into force only after full receipt of the premium chargeable.
- iv. 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 / proposer after the proposal has been submitted but before communication of the risk acceptance by the Company.
- v. I/We declare and consent to the Company seeking medical information from any Doctor or from a hospital who at anytime has attended on the life to be insured / proposer or from any past or present employer concerning anything which affects the physical or mental health of the life to be assured / proposer and seeking information from any insurance company to which an application for insurance on the life to be assured / proposer has been made for the purpose of underwriting the proposal and / or claim settlement.
- vi. I/We authorize the company to share information pertaining to my proposal including the medical records for the sole purpose of proposal underwriting and/or claims settlement and with any Governmental and / or Regulatory Authority.
- vii. Receipt of the Proposal form by the Company shall not be construed as acceptance of proposal. I hereby agree that the insurance coverage shall commence only on realization of full premium and on receipt of complete medical reports (wherever applicable) and subject to individual underwriting by the Company. The Company at its sole discretion reserves the right to accept or reject or load any proposal without assigning any reason thereof.
- viii. I understand that the Policy shall become void at the Company's option, in the event of any untrue or incorrect statement, misrepresentation, non-description or non-disclosure of any material fact in the Proposal form/personal statement, declaration and connected documents or any material information having been withheld by me or anyone acting on my behalf.
- ix. I hereby declare that the person(s) proposed to be insured would submit to medical examinations, before the nominated doctors of the Company, or undergo diagnostic or other medical tests, as suggested by the Company for its underwriting.
- x. I consent to provide a valid age proof and identity proof at the time of claims or any other time when required by the Company.
- xi. I/We consent to receive information from the Company through physical, electronic or telecommunication means from time to time.
- xii. I hereby declare on my behalf & on behalf of all persons proposed to be insured 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/We am/are authorized to propose on behalf of these other persons.
- xiii. I/We here by state that the above mentioned address shall be taken as address on record for the purpose of GST.
- xiv. I/We hereby confirm that the contents of the proposal form and connected documents have been fully explained to me/us and I/We have fully understood the significance of the proposed contract

AML GUIDELINES

1. 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.
2. I understand that the company has the right to call for document to established sources of funds.
3. 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.

Place: _____

Date: d d m m y y y y

Signature of the Proposer:

Vernacular Declaration stating that the contents of this proposal form have been read over & fully explained to me in _____ language. I further confirm & declare that contents read over & explained to me have been understood by me.

Signature/Thumb Impression of the Proposer: _____

Identified by Name & Signature : _____

Date: d d m m y y y y

Place: _____

Prohibition of Rebates - Section 41 of the Insurance Act, 1938 as amended by Insurance Laws (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 renewing or continuing a policy accept any rebate, except such rebate as may be allowed in accordance with the published prospectuses or tables of the insurer.
2. 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.

IRDAI Registration No. 103. Reliance General Insurance Company Limited. Registered Office: H Block, 1st Floor, Dhirubhai Ambani Knowledge City, Navi Mumbai - 400710. **Corporate Office:** Reliance Centre, South Wing, 4th Floor, Off. Western Express Highway, Santacruz (East), Mumbai - 400 055

IRDAI Registration No. 103. UIN: IRDA/NL-HLT/RGI/P-T/V.I/321/13-14

Registered & Corporate office Address

IRDAI Registration No. 103. Reliance General Insurance Company Limited.

Registered Office: H Block, 1st Floor, Dhirubhai Ambani Knowledge City, Navi Mumbai - 400710.

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For any assistance call **1800 3009** (toll free)