

Kshema Hospi DinDhan Suraksha (Retail)

Proposal Form

Proposal No.

E-mail ID: customer.support@kshema.co | Website: www.kshema.co

INTERMEDIARY DETAILS

Intermediary Name: Intermediary Contact No.
Intermediary Code: Intermediary Email Id:

RELATIONSHIP MANAGER

RM Name: RM Contact No.
RM Code: RM Email Id:

PROPOSER / INSURED DETAILS

Name (First Name): Last Name:
Are you Proposer (Payer) Insured Both Date of Birth (DOB):
Communication Address:

Is your Permanent Address same as Communication Address? (If not, then please provide Permanent Address):

Gender: Nationality: Email Id (if available):
Contact No: Occupation:
If other, please mention here:
Aadhaar/PAN Number:

SUBJECT MATTER DETAILS

Per day hospitalisation amount: Limit per Policy year:
Base Sum Insured: Policy Period: 1 Year: 2 Year: 3 Year:
Height (ft/inch): Weight (kg):
Do you or any of your family members have a hereditary medical condition? Yes: No:
If Yes please mention here:
Do you have any Pre Existing Disease?:
If Other please mention here:
Name of Disease: From how long you are having:
Any Medication: If you are currently under treatment?
Were you hospitalised or suffering from any ailment or under treatment in last 6 months:
Cause of Hospitalisation/Treatment: From how long is the Hospitalisation:
Any medication? Yes: No: If you are currently under treatment? Yes: No:

Medical History: (Please answer the below questions with Tick Mark or Cross Mark Only.)

	You	1 Name of family members	2 Name of family members	3 Name of family members	4 Name of family members	5 Name of family members
Are/Is you/the person proposed for insurance in good health and free from physical and mental disease or infirmity or medical complaints						
Are you currently Pregnant?						
Do you intake below item, if yes then please specify amount/day						
Alcohol (peg/day) (1 Peg = 30 ml)						
Tobacco (Cigarette/Bidi/Gutkha/Pan Masala, etc.)						

Have any of the persons proposed to be insured ever suffered from/ are currently suffering from any of the following:

Genetic Disorder, HIV/AIDS						
Asthma, Blood Pressure, Cholestrol, Diabetes						
Acid Attack, Anaemia, Blindness						
Any disorder/ disease of the stomach, Intestine, Liver, Gall bladder, Pancreas, Kidney (except Renal Stones), Urinary Bladder, Urinary Tract						
Cataract or other diseases of the eye Disease of Bones/ Joint including arthritis, rheumatic pain, slipped disc, spinal disorder, injury to Ligaments or Paralysis						
Disease of Fistula/Prostrate, Piles, Hernia, Varicose veins						
Gynaecological disorder such as DUB, Fibroid Uterus, Prolapsed Uterus, Ovarian cyst or breast or any specific gynaecological disorders or have undergone caesarean/ Hysterectomy						
Disease of Central Nervous System						
Psychiatric Disorder, Thyroiditis/Goitre						
Benign Tumor, Pre-cancerous Lesion, Ulcer, boil, cyst or wound etc. which does not heal or improve despite treatment						

If you answered 'Yes' to any of the prior questionnaire, please give details in the following table.

Name of the Person to be insured	Illness(es)	Date of Last Consultation (DD/MM/YYYY)	Treatment(s) Undergone	Name of the treating Doctor	Hospital Name & Phone Number	Present Status

Are you or any of the insured person is PEP (Politically Exposed Person) or related to PEP? If yes, please mention

Info Tab - Politically Exposed Persons (PEPs) are individuals who are or have been entrusted with prominent public functions in a foreign country, example, Heads of State or of Governments, senior politicians, senior government / judicial / military officials, senior executives of state-owned corporations, important political party officials, etc., including their family members and close relatives.

NOMINEE DETAILS

Name of the insured member	Name of the Nominee	Mobile Number	Relationship	Address of Nominee	Date of Birth

Note * For all the dependents nominee is Proposer and for only Proposer we need to collect the Nominee details

APPOINTEE DETAILS (Where nominee is a minor)

Name of Appointee	Relationship	Address of Appointee	Date of Birth

BANK DETAILS (PROPOSER)

Account Number: Bank Name:

Account Holder Name: IFSC/MICR Code:

DECLARATION

- That the statements, answers, and particulars provided above are true and complete to the best of my/our knowledge, and that I am/we are duly authorized to propose on behalf of all persons to be insured.
- That the relevant documentation and product information have been read and understood, including the features and benefits, and the decision to purchase this product is made voluntarily.
- That the information provided shall form the basis of the insurance policy, and coverage shall commence only upon full payment of the premium.
- That any changes in occupation or general health occurring after submission of this proposal but before acceptance of risk by the Company shall be notified in writing.
- That any misstatement, suppression, or non-disclosure of material information, or failure to notify the Company of any material change, may entitle the Company to repudiate any claim or declare the policy void.
- That consent is given to the Company to obtain medical information from any doctor, hospital, employer, or insurer for the purposes of underwriting and/or claim settlement.

DECLARATION

- That the mobile number [] and email ID [] provided in the proposal form are registered in my/our name, and authorization is granted to the Company to send all communications, including claim-related information, to the provided contact details.
- That the Company may share, collect, or validate KYC-related documents/information with financial institutions, credit rating agencies, and other entities, and may confidentially share contact details and other information with service providers or third-party agencies for processing or servicing, as required by law or regulatory authorities, or for fraud prevention.
- That authorization is granted to the Company to retrieve insurance history and other relevant information from the Insurance Information Bureau, and consent is given to receive regular updates, alerts, and promotional communications.
- That the Company may share proposal-related information, including medical records, with Governmental and/or Regulatory authorities, including through ABHA, solely for underwriting and/or claims settlement purposes.
- That the Company's Privacy Policy, as published on its website, has been read and understood by me/us and/or the insured persons.
- That authorization is granted to the Company and its representatives to contact me/us via phone, SMS, email, WhatsApp, or other communication methods, overriding any registration under the National Do Not Call Registry.
- That consent is given for the collection, use, and disclosure of personal information by the Company for insurance services, including underwriting, claims processing, and customer service. Personal information may be shared with third-party service providers and regulatory bodies, and I/we retain the right to access, correct, or delete such information by contacting customer.support@kshema.co. This consent remains valid as per IRDAI Regulations 2025 and other applicable laws.
- That the contents of the Proposal Form and accompanying documents have been fully explained and understood including the significance of the proposed insurance.
- That courteous and professional conduct will be maintained in all communications with the Company, and acknowledgment is given to the Company's commitment to the same. Any inappropriate behaviour may result in termination of interaction, restricted access, and potential legal action.
- That the terms and conditions stated above have been fully understood and agreed to. All relevant health conditions and disabilities of the proposed insured individuals have been truthfully disclosed, and no individual proposed to be insured is currently facing any disability. Authorization is provided willingly and with informed consent.

I have read the above and confirm having noted the details.

Place:

Date:

(Name and Signature)

DECLARATION AND CONSENT

Source Of Fund

Salary: []

Business: []

Others: []

(In case of others, please specify)

I/we hereby declare and confirm that the premium has been paid out of legally acquired sources of income and the subsequent premiums if any, will continue to be paid out of legally declared and assessed source of income.

CKYC Number:

I/we hereby give my/our consent to the Company to verify and obtain my/our identity/address proof through Central KYC Registry or Goods and Service Tax Portal or Ministry Of Corporate Affairs Portal or National Securities Depository Limited portal for the purpose of undertaking KYC.

I hereby grant consent to Agent/Broker/Corporate Agent or any other licensed intermediary to share my KYC (Know your Customer) and customer due diligence information with kshema General Insurance Limited for the purpose of my insurance proposal.

Electronic-Insurance Account:

Do you want to open e-IA account: Yes: No:

If Yes, Please provide e-IA No. to deposit your insurance policy.

E-IA Number:

SECTION 41 OF THE INSURANCE ACT 1938

Prohibition of Rebates

Payment of rebates is expressly prohibited under Section 41 of the Insurance Act, 1938.

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 or 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 a policy accept any rebate except such rebate as may be allowed in accordance with the prospectus or tables of the Insurer.
2. Any person making default in complying with the provisions of this Section shall be punishable with fine, which may extend to ten lakh rupees.