Liberty General Insurance Limited

10th Floor, Tower A, Peninsula Business Park,
Ganpatrao Kadam Marg, Lower Parel, Mumbai - 400 013

Phone: +91 22 6700 1313 Fax: +91 22 6700 1606

Email: care@libertyinsurance.in

IRDA registration number: 150 ◆ CIN: U66000MH2010PLC209656



LIBERTY GROUP HEALTH POLICY

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Company/Proposer Details																						UR	N -	LH	015	V32	021
Name of Insured/ Proposer:											Τ		Τ	Τ								Т					
Address of Insured/ Proposer:						\top	\top		†		T	T	T								\vdash	\top	Т	П			
Business of Insured/ Proposer:																											
Contact Person at Insured:	\perp			Co	ontac	ct No	0. :		_		_										L	_					
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Name of the Intermediary:						Т					Т	Τ	Τ	Τ							П	Т					
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		-																									
Premium deletion during the year (Exclusive	01 G	SI)																									
Final Premium (Exclusive of GST)																											
Member Details																											
Basis of Premium Charging																					\top						
to be specified whether per																											
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Final no. of Members at expiry							\dashv														+						
Members to be covered on Renewal / New																					+		—	—			
(Age band wise and Sum Insured wise d																											
emography to be provided as per attached format for each location)																											
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Reimburs				se	mer	nt		С	ash	less	S										\top						
Claims Paid as on date (Rs)																											
Claims outstanding as on date (Rs)																											
If OPD cover given, then mention OPD claims separately										n pai r Fa							VVV	VV									
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policy years immediately preceding								of	f the	pre	ece	ding	g tw	o ye	ars	of	ooli	су									
the expiring year.								in	nme	diat	ely	pre	cec	ling	to t	he e	exp	irin	g ye	ear.	\perp						
Family Details																						_	_	_			
Family Definition and Size										_		,		-					Ţ		_	_	_	_			
Whether Additional Children Covered Whether Additional Relationships Covered,										Fan Age									+		—		—				
like brother/sister etc.										yu	- =11			1	y	. v i C		J1 J									

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LIBERTY GROUP HEALTH POLICY

Proposal Form

Whether Existing Benefits covered inder the expiring year policy to be continued as it is - Yes or No (No - Then changes required in the Coverage and imit of benefits to be specified. Ist of Coverages / Benefits	And the expiring year policy to be continued as it is - Yes or No No - Then changes required in the Coverage and imit of benefits to be specified. Set of Coverages / Benefits														
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Sr. No. Emp No. Name of Employee/ Primary member	Name of Employee/ Primary member Name of Dependent Name of Dependent					_									
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Agreement, Declaration & Authorization

"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/us 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/We understand that the information provided by me/us will form the basis of the insurance policy, is subject to board approved underwriting policy of the insurance company and that the policy will come into force only after full receipt of the premium chargeable.

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 or from any past or present employer concerning anything which affects the physical and mental health of the life to be insured and seeking information from any insurance company to which an application for insurance on the life to be insured 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/our proposal including the medical records for the sole purpose of proposal underwriting and/or claims settlement and with any Government and/or Regulatory Authority.

Date	Signature of Proposer/Authorized signatory
AML Details:	
Please provide Permanent Account Number (PAN) if premium ar	mount exceeds Rs. 1 Lac
as an inducement to any person to take out or renew or continu rebate of the whole or part of the commission payable or any rebate continuing a policy accept any rebate, except such rebate as m	ct 1938 (4 of 1938) No person shall allow or offer to allow, either directly or indirectly, the an insurance in respect of any kind of risk relating to lives or property in India, any attended of the premium shown on the policy, nor shall any person taking out or renewing or any be allowed in accordance with the published prospectus or tables of the insurer'. It is section shall be punishable with fine which may extend to ten lakh rupees.
Acknowledgment	
Application No. :	Date: d d m m y y y y
We acknowledge with thanks the receipt of your application and a	mount by Cast/Cheque/Demand Draft/Others of the amount of
INR dated	. drawn on
Signature of the receiver & office Seal :	
FOR OFFICE USE ONLY	
Intermediary Name:	Intermediary Code:
Sales Manager Name:	Intermediary Code: Sales Manager Code:

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LIBERTY GROUP HEALTH POLICY **Proposal Form**

Annexure - 1

Sr. No.	Emp No.	Name of Employee/ Primary member	Name of Dependent	Relationship	DOB	DOJ	Designation	Gender	SI

Nominee Name & Relationship	disease/Injury (Y/N)	*Whether Pregnant(Y/N) If Yes, please give no. of months pregnancy	Ac No	IFSC	Bank Name	Branch

^{*}Applicable to female members and if opted for Maternity benefits.