



- Nature of Travel: _____ (Air, Rail, Road, etc.)
- Geographical Scope: _____ (Country/Continent)
- Trip Type: Single Trip OR Annual Multi Trip
- Coverage Period: _____ Days (in case of Annual Multi Trip)
- Purpose of visit Business Seminar Leisure Adventure Sports
 Educational Pilgrimage Others, please specify _____
- Maximum Trip Duration (in a single trip): _____ Days



1. DETAILS OF INSURED PERSONS

- Note:**
1. This list will be attached to and forming part of the proposal form and policy to be issued.
 2. Separate list should be attached in respect of persons proposed to be covered under each Sum Insured.
 3. All nominations will be in accordance with Section 39 of the Insurance Act 1938.
 4. A Minor should not be declared as nominee.

Coverage Category	No. of Employees	No of Members
Category A*		
Category B*		
Total		

A and B might be defined within a group, depending on the seniority, nature of work etc.
For Named member / Employees: Fill the Annexure 1
Please attach additional sheets, if space not sufficient to complete details.

2. BENEFITS:

Category	Basis of Coverage (Individual/Floater)	Floater Unit (in case of Floater)	Selected Benefits
Category A			Refer Annexure II.A
Category B			Refer Annexure II.B

Note: All the benefits can be chosen for the category. Please select the benefits that you wish to avail as per Annexure 2

3. DECLARATION & AUTHORISATION

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 mode of travel, 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 travel information from the travel organizer, service provider or 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 mode of travel, incident details, loss or inconvenience caused to the insured, 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.

I submit that the foregoing information is true to the best of my knowledge, and accept that if found to be untrue in any form, the Company reserves the right to alter/ cancel the coverage available under this Policy.

Note: The liability of the Company does not commence until full premium has been realized by the Company and the acceptance of the proposal has been formally intimated to the insured.

Principle Contact Person Name: _____

Date: _____

Signature of the Proposer: _____

Place: _____

4. SALES PERSON/INSURANCE AGENT/INTERMEDIARY DECLARATION

I, _____ (Full Name) in my capacity as an insurance Agent/ Specified Person of the Corporate Agent/authorized employee of the Broker or authorized Sales Person of the Company, 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 (Agent / Corporate Agent / Broker / Sales Person): _____

Date: _____
Place: _____

Signature of Proposer/ Intermediary: _____

5. PROHIBITION OF REBATES (SECTION 41 OF INSURANCE ACT, 1938, AS AMENDED)

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 10 lakh rupees.



Annexure *1:

Sr No	Name of Insured Person	Unique Employee No/Customer Relationship number/ Passport Number	Relationship of family with primary Insured	Date of Enrolment/ Joining	Age	Gender	Nominee Name & Relationship with Insured Person	Mobile No.	Email ID	Address of the Insured
1.										
2.										
3.										
4.										
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18.										
19.										
20.										

Note: *This list is indicative and details could be modified according to the Nature of Group/ Policy.

In case of Student Travel, we need additional information as below:

Sr No	Name of Insured Person	Details & Duration of Course	Name of University & Location	Date of Birth	Sponsor Name	Relationship with Proposer
1.						
2.						
3.						
4.						
5.						
6.						
7.						
8.						
9.						
10.						

Note: *This list is indicative and details could be modified according to the Nature of Group/ Policy.

Annexure 2:

Please provide details pertaining to sum insured or conditions opted for each benefit and enter "None" for Cover Benefits not opted for

Benefits selected for Category <Name>

1. Benefits

S. No.	Name of the Benefit	Benefit Type	Covered Events	Sum Insured	Additional Conditions (Provide Details)
1	Accidental Death Benefit				
2	Permanent Total Disability				
3	Permanent Partial Disability				
4	Temporary Total Disability				
5	Medical Expenses Reimbursement				
6	Day Care Treatment Cover				
7	Hospital Fixed Allowance				Min. no of days of hospitalization required: _____
8	Hospital Daily Allowance			Rs _____ per day	Min. days of hospitalization required: _____ Max. no. of days covered: _____
9	Compassionate Visit				Min. no of days of hospitalization required: _____
10	Compassionate Visit Stay				Min. days of hospitalization required: _____
11	Emergency Visit				Min. no of days of hospitalization required: _____
12	Ambulance and Emergency Transportation				
13	Evacuation (Medical & Catastrophe)				
14	Repatriation of Mortal Remains				
15	Funeral Expense				
16	Mobility Cover				
17	Child Education Cover				
18	Physiotherapy				
19	Disappearance Cover				Tenure: _____
20	Hardship Allowance				
21	Income Protection Cover			Rs _____ per day	Min. no of days: _____ Max. no. of days: _____
22	Kidnap/Hijack Cover				Min. no of hours: _____
23	Convenient Travel Option				
24	OPD Treatment				
25	Trip Delay				Min. no of hours _____
26	Trip Cancellation & Interruption				Min. hours of hospitalization required: _____
27	Trip Curtailment				Min. hours of hospitalization required: _____
28	Delay of Checked-in Baggage				Min. no of hours _____
29	Loss of Checked-in Baggage				



S. No.	Name of the Benefit	Benefit Type	Covered Events	Sum Insured	Additional Conditions (Provide Details)
30	Loss of Baggage and Personal Effects				
31	Loss of Passport				
32	Loss of Identification Documents				
33	Visa Rejection/Denial				
34	Personal Legal Liability				
35	Financial Emergency Cash				
36	Carrier Cancellation				
37	Cancellation of Carrier by Insured Person				Deductible amount: _____
38	Travel Cancellation				
39	Denied Boarding - Carrier				Max. no of hours allowed for new ticket booking: _____
40	Missed Carrier				Deductible amount: _____
41	Missed Event				Deductible amount: _____
42	Missed Connection				Min. no of hours: _____
43	Denied Hotel Accommodation				
44	Emergency Hotel Requirement				
45	Emergency Return of Immediate Relative				Min. no of days of hospitalization required: _____
46	Replacement of Staff				Min. no of days of hospitalization required: _____
47	Missed Bill Payment				
48	EMI Protection			EMI amount: _____ Sum Insured: _____	
49	Fraudulent Charges (Payment Card Security)				
50	Rental/Third Person's Vehicle Damage Protection				
51	Loss/Damage of Rented Equipment				
52	Golfer's Hole-in-one				
53	Loss/Damage of Own Equipment				Deductible amount: _____
54	Pet Cover				
55	Fire and Allied Perils (Home Building & Contents)				
56	Home Insurance Cover				
57	Study Interruption				Min. no of days of hospitalization required: _____
58	Sponsor Protection				
59	Bail Bond				
60	University Insolvency				Max. no of days of accommodation: _____
61	Vision Care				
62	Additional Services				

2. Cover Options

S. No.	Name of the Benefit	Benefit Type	Covered Events	Sum Insured	Additional Conditions (Provide Details)
1	Pre-Existing Diseases (In case of life-threatening medical condition)				Pre-Existing Disease details: _____ (if applicable)
2	Extended Cover in the Country of Residence				Max. no of days covered: _____
3	Automatic Extension				Extended no. of days: _____
4	Adventure Sports Injury				
5	Treatment for Alcoholism and Drugs Dependency				
6	Maternity				
7	New Born Baby Medical Expenses				
8	Additional Buffer Sum Insured for the Group			Corporate Floater Sum Insured: _____	
9	Group deductible				Deductible amount: _____
10	Restoration of Sum Insured			___% of Sum Insured	Limited to ___ time(s) per year
11	Personal Accident (Common Carrier)				
12	Additional Permanent Total Disability				
13	Additional Temporary Total Disability				
14	Loss of Valuables/Money/Any kind of Securities				

3. Waiting Period

Sr No.	Waiting Periods	Selected Period
1	Initial Waiting Period	
2	Pre-Existing Disease Waiting Period	
3	Maternity Waiting Period	

Special Conditions (if any):

1. Currency used for claim settlement: _____
- 2.

Declarations (if any):

- 1.
- 2.



Annexure 3:
(applicable in case of Pet Cover)

Sr No	Name of Pet	Identification Mark (Nose print, Tattoo etc)	Age	Gender	Pet Type (Breed, Animal etc)	Coverage Category	Address of the Insured
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Note: *This list is indicative and details could be modified according to the Nature of Policy.