

DIGIT TOTAL PROTECT POLICY
Proposal Form
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Corporate office: Atlantis, 95, 4th B Cross Road, Koramangala Industrial Layout, 5th Block, Bengaluru, Karnataka 560095

- This proposal will be the basis of the insurance policy that we issue. You must disclose all facts relevant to all person(s)/asset(s) proposed to be insured that may affect the Company's decision to issue a policy or its terms. Non-compliance may result in avoidance of the policy.
- If there is insufficient space for you to provide information, whether as requested or otherwise, please attach a separate sheet duly signed or affixed with thumb impression.
- In case You require the hard copy of the Policy and related documents, please provide Your Consent: Yes/No
If You opt not to receive the hard copy of the Policy and related documents, we shall share these with You in Electronic Form i.e. Via E-mail or Direct Download from Our Website.
- Please submit KYC document
- If you are in doubt, you can get in touch with your agent/intermediary or call us at 1800 258 4242 or e-mail at [hello](mailto:hello@godigit.com) along with the Proposal Form, if applicable. [@godigit.com](mailto:hello@godigit.com)

Details of Proposer/Policy Holder		Policy Details			
Name of the Proposer		Date of Birth (DD/MM/YY)			
Address of Proposer		Marital Status			
Mobile No & Email ID		*Policy Period	From	DDMMYYYY	00:01 Midnight
Occupation	Salaried / Self Employed / Professional / Retired / Student/ Housewife/ Other		To	DDMMYYYY	00:01 Midnight
PAN Number		Partner Contact and Email ID			
Partner Code and Name					
ABHA ID (If Applicable)					

*Policy Period Options: Less than a year/ 1 Year/ 2 Years/ 3 Years.

Details of Insured Members including the Proposer (if Proposer is Insured)

Member No.	Full Name	Relationship with Proposer	Date of Birth (DD/MM/YY)/ Age	Gender (M/F)	Height (Cms) and Weight (Kgs)	*Detailed Description of Occupation/Service	Gross Monthly Income	ABHA ID	Nominee/Assignee Name and Relationship with Insured
1									
2									
3									

*Detailed Description of Occupation/Service to be provided. Also mention if you are involved in any hazardous activity or Armed forces.

Coverage Details

Section with Benefits	Sum Insured (INR) Opted	Limits Opted	Waiting Periods /Time Excess Opted	Co-Payment Opted (%)	Other Information
Section 1. Accidental Death	INR	NA	NA	NA	
Section 2. Permanent Total Disablement	INR	NA	NA	NA	
Section 3. Permanent Partial Disablement	INR	NA	NA	NA	
Section 4. Loss of Income Benefit	Weekly Benefit Amount: INR _____	NA	Time Excess: _____ Weeks	NA	Total Number of Weeks Opted: _____
Section 5. Children Education Benefit	INR	NA	NA	NA	
Section 6. Marriage Expense for Children Benefit	INR	NA	NA	NA	
Section 7. Orphan Benefit For Children	INR	NA	NA	NA	
Section 8. Funeral Expenses	INR	NA	NA	NA	
Section 9. Transportation Expenses	INR	NA	NA	NA	
Section 10. Trauma Counselling	INR	NA	NA	_____%	
Section 11. Accidental Hospitalization Cover	INR	NA		_____%	Individual/Floater

					Sum Insured Basis: Basis 1 / Basis 2
A. Hospitalization Expenses		NA			
B. Day Care Procedure	*Inbuilt	NA			
C. Pre-hospitalization Expenses	*Inbuilt	Up to _____ Days			
D. Post hospitalization Expenses	*Inbuilt	Up to _____ Days			
E. Dental Treatment	*Inbuilt	NA			
F. Road Ambulance	*Inbuilt	1 % of Section 11. A. Sum Insured Maximum up to INR 5000			
G. Second Medical Opinion	*Inbuilt	NA			
H. Transportation of Imported Medicine	*Inbuilt	NA			
Section 12. Home (Domiciliary) Hospitalization	INR	NA	NA	___%	
Section 13. Long Hospitalization Cash Benefit	INR	Minimum _____ Days Hospitalization	NA	NA	
Section 14. Daily Hospital Cash Cover	INR _____ Per Day	Up to _____ Days	Time Excess: ___ Days	NA	
Section 15. Out-patient Benefit	INR	NA	NA	___%	
Section 16. Emergency Air Ambulance	INR	NA	NA	___%	
Section 17. Coma Benefit Cover	INR	NA	NA	NA	
Section 18. Fracture Cover	INR	NA	NA	NA	
Section 19. Burns cover	INR	NA	NA	NA	
Section 20. Lifestyle Modification	INR	NA	NA	___%	
Section 21. Expense for External Aids and Appliances	INR	NA	NA	___%	
Section 22. Compassionate Visit	INR	NA	NA	___%	
Section 23. Miscarriage Due to Accidental Injury	INR	NA	NA	NA	
Section 24. Adventure Sports Cover			-		
A. Death	INR	NA	NA	NA	Option Opted: Option 1 / Option 2 / Option 3
B. Permanent Total Disablement	INR				
C. Accidental Hospitalization	INR	NA	NA	___%	
Section 25. Critical Illness	INR	NA	Initial Waiting period: _____ Days		Plan Opted: A/B/C
Section 26. HIV Cover	INR	NA	Initial Waiting period: _____ Days	NA	
Section 27. EMI Protection Cover	Sum Insured: INR _____ EMI Amount: _____	Up to _____ Mo nths	Minimum Unemployment Period :1 Month Initial Waiting period for Critical Illness Cover: _____ Days		Cover Opted: <input type="radio"/> Death <input type="radio"/> Permanent Total Disablement <input type="radio"/> Permanent Partial Disablement <input type="radio"/> Critical Illness

*Inbuilt – Sum Insured for these Benefits are not separately available but are a part of Section 11. A. Hospitalization Expenses Sum Insured.

“Cumulative Bonus” Opted [Applicable for Section 1, 2, 3 and 11 only, if opted]: _____% for Each Claim Free Year Subject to Maximum of _____%

Cumulative Bonus Options are as below:

a. Cumulative Bonus of 5%, 10% and 20% Cumulative Bonus each year. Cumulative Bonus can be accrued up to a maximum of 25%, 50% and 100% respectively.

b. If you opt for a higher Cumulative bonus of 50%, the same can be accrued either up to 100% or 150% based on the option selected by you.

Terrorism Covered: Yes/No

On-Duty Cover Opted

MEDICAL HISTORY

Have any of the person proposed to be insured ever suffered from / are suffering from any of the following and/or having any of the habits mentioned below: Please tick "YES" for insured wherever applicable and provide details in the table below:

Sr. No.	Medical History / Habits	Yes/No	Please Tick the “Member Number “who had/having mentioned Medical History/Habits	Diagnosis Since (In Years)
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1	Are you taking any medicines, prescribed or otherwise (Applicable for Critical illness)?	1	2	3	4	5	Up to 1	2	3	4	> 4
2	Any history of consultation or hospitalization (including day care) in last 4 years (other than uneventful maternity/delivery in case of female customer) (Applicable for Critical illness)	1	2	3	4	5	Up to 1	2	3	4	> 4
3	Any diagnostic tests like Blood/ECG/ECHO/CT or MRI Scan etc., in last 4 years other than preventive health check up with normal reports (Applicable for Critical illness)	1	2	3	4	5	Up to 1	2	3	4	> 4
4	Do you have undiagnosed symptoms like chest pain, weakness, weight loss, dizziness, joint pain, change in bowel habit, difficulty in breathing, pain in abdomen, bleeding/pain while passing stools? (Applicable for Critical illness)	1	2	3	4	5	Up to 1	2	3	4	> 4
5	Have you or any member of your family proposed to be insured, suffered or suffering from any disease/ailment/adverse medical condition of any kind especially Heart/Stroke/Cancer/Renal disorder/Joint/Gastrointestinal disease/Respiratory /neurological / endocrine / blood related disorder /Mental disorder (Applicable for all Sections)	1	2	3	4	5	Up to 1	2	3	4	> 4
6	Have you or any member of your family proposed to be insured, suffered or suffering from any physical impairment or disability? (Applicable for all Sections)	1	2	3	4	5	1 Up to 1	2	3	4	> 4
7	Was any proposal for life, health, hospital daily cash or critical illness insurance declined, deferred, withdrawn or accepted with modified terms? (Applicable for all Sections)	1	2	3	4	5	Up to 11	2	3	4	> 4
8	Do you Smoke tobacco? If yes, Number of sticks per day.	1	2	3	4	5	Up to 1	2	3	4	> 4
9	Do you Chew tobacco? If yes, Number of consumptions per day.	1	2	3	4	5	Up to 1	2	3	4	> 4
10	Do you Consume Alcohol If yes, frequency and amount of consumption.	1	2	3	4	5	Up to 1	2	3	4	> 4

Additional details of Disclosure of Each member

Member Number	Details of Previous accident or Disability or Pre-existing Illness or Symptoms or Hospitalization or Diagnostic	Duration of such disability or Illness or Symptoms	Date of Last Consultation	Treatment Details with Treating Doctor Details	Result of the Treatment (Ongoing/Complete Recovery/ Recurrent or like to Recur)
Member Number 1					
Member Number 2					
Member Number 3					
Member Number 4					
Member Number 5					

EXISTING INSURANCE POLICY

Member Number	Do you have any other Personal Accident Policy or Critical Illness Policy (yes/no)	Policy Number	Policy Sum Insured	Name of the Insurer	Period of Insurance	Claims Receivable/Received	Details of Life Insurance (If any)

Member Number 1							
Member Number 2							
Member Number 3							
Member Number 4							
Member Number 5							

CUSTOMER BANK ACCOUNT DETAILS

Bank Account No.	Branch	IFSC Code	Bank Name

GST & PREMIUM PAYMENT TERM DETAILS

GST State Code		GSTIN	
Premium Payment Term:	Yearly / Half Yearly / Quarterly / Monthly		

Note: Installment can also be paid through ECS or NACH mode. In cases where monthly installment is allowed by NACH or ECS mandate, three (3) installments need to be paid at the inception of the Policy.

DECLARATION & WARRANTY ON BEHALF OF ALL PERSONS PROPOSED TO BE INSURED

- 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 authorized to propose on behalf of these other persons.
- 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.
- 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.
- 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.
- 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."

****Please read declaration wordings carefully before signing the proposal form.**

Date:

Signature of the Proposer

Place:

Declaration from Person filling the form in case proposer is unable to sign or signs in vernacular:

I hereby certify that the contents of the proposal form and/or any other documents used towards solicitation have been fully explained to the Proposer and that he/ she/they have fully understood the said contents. I hereby confirm that the responses have been recorded to the best of my ability.

Date:

Place:

Signature (on behalf of the Proposer)

Name & Relationship with Proposer:

INSURANCE ACT 1938 SECTION 41- Prohibition of Rebates

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 a policy accept any rebate, except such rebate as may be allowed in accordance with the published prospectus or tables of the insurer. ANY PERSON MAKING FAULT IN COMPLYING WITH THE PROVISIONS OF THIS SECTION SHALL BE PUNISHABLE WITH FINE WHICH MAY EXTEND TO TEN LAKHS RUPEES.

Go Digit General Insurance Ltd, A Company incorporated under Indian Companies Act, 2013 and licensed by Insurance Regulatory and Development Authority of India [IRDAI] vide Reg No. 158, Corporate Identification Number U66010PN2016PLC167410, Reg. Address Atlantis, 95, 4th B Cross Road, Koramangala Industrial Layout, 5th Block, Bengaluru 560095. Website: www.godigit.com

CUSTOMER IDENTIFICATION PROCEDURE (AS PER KYC NORMS OF IRDAI)

- Please submit clear and legible copy of one document (valid and effective as on date of claim submission) each from Part A and Part B and your recent passport size photograph (not more than 6 months old) in case premium amount exceeds Rs 100,000.

- a. Photograph
- b. Part A (Identity proof, Anyone of below)
 - 1. PAN Card (If PAN Card is not available please submit any of the documents mentioned below)
 - 2. Passport
 - 3. Voter's Identity Card
 - 4. Driving License
 - 5. Personal Identification and Certification of the employees for your identity
 - 6. Aadhar (Letter issued by Unique Identification Authority of India containing details of name address and Aadhar Number)
 - 7. Job Card issued by NREGA duly signed by an officer of the State Government
- c. Part B (Address proof, Anyone of below)
 - 1. Electricity Bill not older than 6 months from the date of Insurance Contract
 - 2. Telephone Bill pertaining to any kind of telephone connection like mobile, landline, wireless etc, provided it is not older than 6 months from the date of claim submission
 - 3. Ration Card
 - 4. Valid lease agreement along with rent receipts which is not more than 3 months old as a residence proof
 - 5. Saving Bank Passbook with details of permanent/ present residence address (updated up to 1 month prior to claim sub-mission document)
- 6. Statement of saving bank account with details of present/ present address (updated up to 1 month prior to claim submission document)