# Digit Health Care Plus Policy
## Proposal Form
## URN: (GODT/IND/HL/1920/01)
## UIN: GODHLIP25037V042425

a. 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.
b. 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.
c. 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.
d. Please submit KYC document
e. 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@godigit.com along with the Proposal Form, if applicable.

**PROPOSER DETAILS**

| | | | | | |
|---|---|---|---|---|---|
| **Name of the Proposer** | | **Date of Birth (DD/MM/YY)** | | | |
| **Address of the Proposer** | | **Marital Status** | Single / Married | | |
| **Mobile No** | | **Occupation** | Salaried / Self Employed / Professional / Others | | |
| | | **First Policy Inception Date** | DD/MM/YYYY | | |
| **Email ID** | | ***Period of Insurance** | From | DDMMYYYY | 00:00 Midnight |
| **Government ID Proof** | | | | | |
| **Partner Code and Name** | | | To | DDMMYYYY | 23:59 Midnight |
| **Partner Contact and Email ID** | | **Policy Type** | Individual / Floater | | |
| **ABHA ID (If applicable)** | | **Family Composition** | | | |
| **Are You existing Digit Employee / Shareholder (If Yes, please provide details)** | ___ Yes / ___ No | **Have you ever taken any Policy from Us? (If yes, please provide details)** | ___Yes/ ___ No | | |

***Period of Insurance can be for 1 Year / 2 Years or 3 Years.**

**DETAILS OF PERSONS TO BE INSURED**

| Member. No. | Full Name | Relationship with Proposer | Date of Birth (DD/MM/YY) | Age | Gender (M/F) | Height | Weight | Occupation | ABHA ID | Nominee /Assignee Name | Nominee /Assignee Relationship with Insured |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 1 | | | | | | | | | | | |
| 2 | | | | | | | | | | | |
| 3 | | | | | | | | | | | |
| 4 | | | | | | | | | | | |
| 5 | | | | | | | | | | | |

**Coverage**

| Section with Benefits | Sum Insured (INR) | Limits | Waiting Periods | Deductible (INR) / Co-Payment (%) | Specific Conditions |
|---|---|---|---|---|---|
| **SECTION 1-HOSPITALIZATION COVER** | | | | | |
| **A. Accidental & Illness Hospitalization Cover** | INR _____ | Accommodation/Room Rent: ___% of Section 1.A Sum Insured<br>**OR**<br>Room Type Opted _____ | A. Initial Waiting Period: _____ Days<br>B. Pre-existing Disease: _____Months<br>C. Specific Waiting Period: _____Months | | |
| A1. Day Care Procedures | *Inbuilt | NA | | | |
| A2. Pre-Hospitalization Expenses | *Inbuilt | Up to _____ Days | | | |
| A3. Post-Hospitalization Expenses | *Inbuilt | Up to _____ Days | | | |
| A4. Dental Treatment | *Inbuilt | NA | | | |
| A5. Road Ambulance | *Inbuilt | 1% of Section 1.A Sum Insured Max up to the INR 5000 | | | |

| | | | | | |
|---|---|---|---|---|---|
| A6. Bariatric Surgery Cover | *Inbuilt | ____% of Section 1.A Sum Insured | | | |
| A7. Psychiatric Illness Cover | *Inbuilt | NA | | | |
| A8. Complimentary Health Check Up | Over and Above the Sum Insured | Up to 0.25% OR 0.5% of the Sum Insured (excluding any cumulative bonus) Subject to maximum of INR 5,000 Per Policy | | | |
| A9. Ayush Cover | *Inbuilt | NA | | | |
| A10. Daily Cash for Choosing Shared Accommodation | *Inbuilt | i.Per Day Cash Benefit – INR _____<br>ii.Maximum No. of days _____<br>Specific Condition: Per day room rent should not be more than INR 3000/ | | | |
| **CUMULATIVE BONUS (if opted)** | INR_____ | | | | |
| **B. Accidental Hospitalization Cover** | INR _____ | Accommodation/Room Rent: ___% of Section 1.B Sum Insured<br>**OR**<br>Room Type Opted _____ | NA | | |
| B1. Day Care Procedures | **Inbuilt | NA | | | |
| B2. Pre-Hospitalization Expenses | **Inbuilt | Up to _____ Days | | | |
| B3. Post-Hospitalization Expenses | **Inbuilt | Up to _____ Days OR | | | |
| B4. Dental Treatment | **Inbuilt | NA | | | |
| B5. Road Ambulance | **Inbuilt | 1% of Section 1.B Sum Insured Max up to the INR 5000 | | | |
| B6. Daily Cash for Choosing Shared Accommodation | **Inbuilt | i.Per Day Cash Benefit – INR _____<br>ii.Maximum No. of days _____<br>Specific Condition: Per day room rent should not be more than INR 3000/ | | | |
| **CUMULATIVE BONUS (if opted)** | INR_____ | | | | |
| **SECTION 2. POST- HOSPITALIZATION LUMPSUM BENEFIT** | *Inbuilt and/or **Inbuilt | Onetime Lumpsum Benefit: _____% of the Claim Amount Approved under Section 1. A &B. | | | |
| **SECTION 3. ORGAN DONOR** | *Inbuilt | NA | As mentioned under Section 1. A. | | Pre and Post upto 5% of claim amount |
| **SECTION 4. EMERGENCY AIR AMBULANCE** | *Inbuilt and/or **Inbuilt | NA | NA | | |
| **SECTION 5. HOME (DOMICILIARY) HOSPITALIZATION** | *Inbuilt and/or **Inbuilt | NA | As mentioned under Section 1. A. and/or Section 1. B. | | |
| **SECTION 6. MATERNITY BENEFIT & NEW BORN BABY COVER** | INR _____ | Limit on Maternity Expenses of Your Second Child: _____% of the Sum Insured under this Section | _____Months | | Pre and Post natal up to 100% of section 6 SI: Opted Yes __ /No___ |
| **SECTION 7. INFERTILITY TREATMENT COVER** | *Inbuilt | 10% of the Section 1.A Sum Insured | ____ months | | |
| **SECTION 8. OUT-PATIENT (OPD) BENEFIT** | INR _____ | NA | As mentioned under Section 1. A. and/or Section 1. B. | Basis 1: Co-Payment of 25% in the First Year of this Section being opted, 10% on First Renewal this Section and No | |

| | | | | | |
|---|---|---|---|---|---|
| | | | | Co-payment from the Second Renewal of this Section<br><br>Basis 2: Nil Co-payment | |
| **SECTION 9. SECOND MEDICAL OPINION** | *Inbuilt and/or **Inbuilt | | | | |
| **SECTION 10. CONSUMABLE COVER** | *Inbuilt and/or **Inbuilt | ____ % of approved claim amount | | | |
| **SECTION 11. UNUSED SUM INSURED BENEFIT** | Yes/No | | | | |
| **SECTION 12. SUM INSURED REFILL BENEFIT** | Yes/No | Once During Policy Period / Unlimited Times | NA | | |
| **SECTION 13. DAILY HOSPITAL CASH COVER** | | | | | |
| A. Accidental & Illness Hospitalization Cover | INR____ Per Day | Up to _____ Days | Initial Waiting Period: _____ Days<br><br>Pre-existing Disease: _____Months<br>Specific Waiting Period: _____Months | | Time Excess: _____ Days |
| B. Accidental Hospitalization Cover | INR____ Per Day | Up to _____ Days | NA | | Time Excess: __ Days |
| **SECTION 14. DAILY CASH FOR ACCOMPANYING AN INSURED CHILD** | INR _____ per day | No. of days_____ | | | |
| **SECTION 15. LONG HOSPITALIZATION CASH BENEFIT** | INR _____ | Minimum _____ Days Hospitalization | - | | |
| **SECTION 16. LOSS OF INCOME COVER** | INR _____ | Block of days _____ | | | Maximum number of times payable ___ |
| **SECTION 17. CRITICAL ILLNESS BENEFIT COVER** | INR _____ | NA | Initial Waiting Period: ____ Days | | |
| **SECTION 18. CRITICAL ILLNESS HOSPITALIZATION COVER** | INR _____ | Accommodation/Room Rent: ___% of Section 18 Sum Insured<br><br>**OR**<br>Room Type Opted<br>_____ | Initial Waiting Period: _____ Days | | |
| **CUMULATIVE BONUS (if opted)** | INR_____ | | | | |
| **SECTION 19. CANCER BENEFIT COVER** | INR _____ | NA | Initial Waiting Period: ____ Days | | |
| **SECTION 20. CANCER HOSPITALIZATION COVER** | INR _____ | Accommodation/Room Rent: ___% of Section 20 Sum Insured | Initial Waiting Period: _____ Days | | |
| **CUMULATIVE BONUS (if opted)** | INR_____ | | | | |
| **SECTION 21. WOMAN CANCER BENEFIT** | INR_____ | NA | Initial Waiting Period: ____ Days | | List of women specific cancer to be covered: |
| **SECTION 22. HEALTH CHECKUP COVER FROM DAY ONE** | INR_____ | | | | Health Check up Package Opted: _____ |
| **SECTION 23. ADVANCE HEART AMBULANCE** | *Inbuilt and/or **Inbuilt | | | | |
| **SECTION 24. ADVANCE CARE** | *Inbuilt and/or **Inbuilt | | | | Upto 100% of SI |
| **SECTION 25. SI MULTIPLIER** | *Inbuilt and/or **Inbuilt | | | | Enhanced SI: ___Multiple times<br><br>If opted: First claim only – Yes/No |

| | | | | | |
|---|---|---|---|---|---|
| **SECTION 26. SUPPORT PLUS** | *Inbuilt and/or **Inbuilt | | | | Per day amount payable _____<br><br>Maximum Number of days ____ |
| **SECTION 27. FASTRACK** | *Inbuilt | | Initial Waiting Period : 30 Day | | Disease/ illness/ condition covered:<br>1.Asthma<br>2.Chronic Obsutructive Pulmonary Disease (COPD)<br>3.Diabetes<br>4.Hypertension<br>5.Hyperlipidemia<br>6.Obesity<br>7.Coronary Artery Disease (PTCA done prior to 1 year)<br>8.Thyroid |
| **SECTION 28. CUMULATIVE BONUS PROTECTOR COVER** | | INR _____ cumulative bonus protection cover amount | | | % of Cumulative Bonus as per base cover |
| **SECTION 29. SMART SAVE** | ___Yes/ ___No | | | | |
| **SECTION 30. WELLNESS BENEFIT PROGRAM** | NA | | | | Please tick Services opted:<br>1. Doctor On Call<br>2. Wellness Coach<br>3. Lab Services and Imaging (For Diagnostic Services)<br>4. Pharmacy (Home Delivery)<br>5. Vital/Physical Activity Monitoring Services<br>6. Reminder Notifications<br>7. Medical Wallet<br>8. Report Aggregation<br>9. Home Care Services<br>10. Ambulance Arrangement Services<br>11. Pick-up and Drop services for consultations<br>12. Prioritizing Appointments<br>13. Mental Wellbeing<br>14. Physiotherapy<br>15. Childcare/Children's Activity<br>16. Out -Patient (OPD) Services<br>17. Fitness |

***Inbuilt – Sum Insured for these Benefits are not separately available but are a part of Section 1. A. Accidental & Illness Hospitalization Cover Sum Insured.**
****Inbuilt– Sum Insured for these Benefits are not separately available but are a part of Section 1. B. Accidental Hospitalization Cover Sum Insured.**
**Insured**

| | | |
|---|---|---|
| **No Claim Bonus Benefit** | INR_____/___ __% | **Option opted:**<br>**A.** Cumulative Bonus: ☐<br>**B.** No Claim Discount: ☐<br>**Other condition:**<br>Maximum Limit on Benefit Accrued: _____<br>Any other conditions _____ |

## Special Terms and Exclusions

**"Cumulative Bonus and No claim discount" [Applicable for section 1A, 1B, 18 and 20 only]**
**Premium Payment Frequency: Yearly/Half-yearly/Quarterly/Monthly**
**In case Unlimited Sum Insured is opted, it means Sum Insured more than INR 3 crore without any limitation. Premium for Unlimited Sum Insured is calculated by multiplying 1.15 to the premium of Sum Insured INR 3 crore.**

## Existing Insurance Policy:

| Member Number | Do you have any other Health Insurance | Policy Number | Policy Sum Insured | Name of the Insurer | Period of Insurance | Claims Receivable/ Received | Details of Life Insurance (If any) |
|---|---|---|---|---|---|---|---|
| 1 | | | | | | | |
| 2 | | | | | | | |
| 3 | | | | | | | |
| 4 | | | | | | | |
| 5 | | | | | | | |
| 6 | | | | | | | |

## Special Terms and Exclusions

1.
2.

## CUSTOMER BANK DETAILS

| Bank Account No. | Branch | IFSC Code | Bank Name |
|---|---|---|---|
| | | | |

## PREMIUM PAYMENT ZONE & GEOGRAPHICAL LIMITS

**Premium Payment Zone**: ☐ Zone A ☐ Zone B ☐ Zone C

**Based on your city of residence, Zones have been classified into three as mentioned below:**

- **Zone A - Delhi & NCR, Greater Hyderabad Area, Mumbai and Greater Mumbai region (including Thane and Navi Mumbai), Gujarat**
- **Zone B Chennai, Bengaluru, Kolkata, Pune**
- **Zone C Rest of India**

**Note:**
**Zone Details:**

- **If You have availed choice of Zone B at the time of Policy Inception and availing treatment in a Hospital which is situated in Zone A, 10% Co-pay would be applicable on admissible claim amount.**
- **If You have availed choice of Zone C at the time of Policy Inception and availing treatment in a Hospital which is situated in Zone B, 10% co-payment will be applicable. on admissible claim amount.**
- **If You have availed choice of Zone C at the time of Policy Inception and availing treatment in a Hospital which is situated in Zone A, 20% Co-pay would be applicable on admissible claim amount.**
- **Zone based Co-pay as mentioned above will not be applicable in case of accidental injury.**

**Geographical Limits:**

| | |
|---|---|
| **Geographical Limits Options** | ☐ Within India ☐ Asia ☐ Worldwide Including USA & Canada ☐ Worldwide Excluding USA & Canada |
| **Options for Co-Payment where Geographical Limit is Outside India** | ☐ 0 % ☐ 5 % ☐ 10 % ☐ 15% ☐ 20% |

**Preferred Care Discount**

- **Do You want to opt for hospitalization in Network Hospitals only** ☐ **Yes** ☐ **No**

***(Please note**- If You opts for hospitalization in Network Hospitals only, discount in premium will be offered. In case a non-accidental claim under Section 1 from a non-network hospital, co-pay of 20% shall be applicable on the admissible claim amount.)*

## 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) | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1 | Are you taking any medicines, prescribed or otherwise? | | 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 | | 1 | 2 | 3 | 4 | 5 | Up to 1 | 2 | 3 | 4 | > 4 |

| | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | uneventful maternity/delivery in case of female customer) | | | | | | | | | | | |
| 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 | | **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? | | **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 | | **1** | **2** | **3** | **4** | **5** | **Up to 1** | **2** | **3** | **4** | **> 4** |
| 6 | Is there any other information relating to your health that has not been prompted by the questions listed above? | | **1** | **2** | **3** | **4** | **5** | **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 | | **1** | **2** | **3** | **4** | **5** | **Up to 1** | **2** | **3** | **4** | **> 4** |
| 8 | Do you Smoke tobacco | | **1** | **2** | **3** | **4** | **5** | **Up to 1** | **2** | **3** | **4** | **> 4** |
| 9 | Do you Chew tobacco | | **1** | **2** | **3** | **4** | **5** | **Up to 1** | **2** | **3** | **4** | **> 4** |
| 10 | Do you Consume Alcohol | | **1** | **2** | **3** | **4** | **5** | **Up to 1** | **2** | **3** | **4** | **> 4** |

**Any additional details with respect to the questions answered "Yes" in the above table:**

| **Member Number** | **Details of Illness with 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 | | | | |

## GST & PREMIUM PAYMENT DETAILS

| | | | |
|---|---|---|---|
| GST State Code | | GSTIN | |
| Premium Payment Term: | Yearly / Half Yearly / Quarterly / Monthly | | |
| | | | |
| Note: Instalment can also be paid through ECS or NACH mode. In cases where monthly instalment is allowed by NACH or ECS mandate, three (3) instalments need to be paid at the inception of the Policy. | | | |
| Premium payment mode: Cash/Cheque/ DD/Card/ECS | | | |
| Cheque No/NEFT Ref No | Bank Name | Date | Amount (Including applicable taxes) |
| | | | |

## 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:

## Vernacular Declaration:

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)

1. 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)