Digit Health Insurance Policy
Proposal Form
URN: (GODT/IND/HL/2223/02)
UIN: GODHLIP25039V022425

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 along with the Proposal Form, if applicable. @godigit.com

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		
PAN Number /AADHAR / Government ID Proof		**First Policy Inception Date**	DD/MM/YYYY		
Email ID		***Period of Insurance**	From	DDMMYYYY	00:00 Midnight
Partner Code and Name			To	DDMMYYYY	23:59 Midnight
Partner Contact and Email ID		**Policy Type**	Fresh/Renewal/Roll-Over /Migration/Portability		
		Family Composition			
ABHA ID					
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:** ☐ **1 Year** ☐ **2 Years** ☐ **3 Years** ☐ **4 Years** ☐ **5 Years**

DETAILS OF PERSONS TO BE INSURED

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

PLAN DETAILS

S.No.	Member Name	Sum Insured	Floater	Deductible	Plan opted
1		2L/3L/4L/5L/7.5L/9L/ 10L/12.5L/15L/20L/25L/ 30L/40L/50L/60L/75L/ 1Cr/2Cr/3Cr	2L/3L/4L/5L/ 7.5L/9L/ 10L/12.5L/15 L/20L/25L/ 30L/40L/50L/ 60L/75L/1Cr/ 2Cr/3Cr	2500/5000/ 7500/10,000/ 15000/20000/ 25000/30,000/ 40,000/50,000	<Double Wallet Plan/Infinity Wallet Plan/Carry Forward Sum Insured Plan/Worldwide Treatment Plan/Early Start Plan/Senior Priority Plan/ Even Protect Plan/ BharatX*>
2		2L/3L/4L/5L/7.5L/9L/ 10L/12.5L/15L/20L/25L/ 30L/40L/50L/60L/75L/ 1Cr/2Cr/3Cr			<Double Wallet Plan/Infinity Wallet Plan/Carry Forward Sum Insured Plan/Worldwide Treatment Plan/Early Start Plan/Senior Priority Plan/ Even Protect Plan/ BharatX*>
3		2L/3L/4L/5L/7.5L/9L/ 10L/12.5L/15L/20L/25L/			<Double Wallet Plan/Infinity Wallet Plan/Carry Forward Sum Insured Plan/Worldwide Treatment Plan/Early Start Plan/Senior

		30L/40L/50L/60L/75L/ 1Cr/2Cr/3Cr			Priority Plan/ Even Protect Plan/ BharatX*>
4		2L/3L/4L/5L/7.5L/9L/ 10L/12.5L/15L/20L/25L/ 30L/40L/50L/60L/75L/ 1Cr/2Cr/3Cr			<Double Wallet Plan/Infinity Wallet Plan/Carry Forward Sum Insured Plan/Worldwide Treatment Plan/Early Start Plan/Senior Priority Plan/ Even Protect Plan/ BharatX*>
5		2L/3L/4L/5L/7.5L/9L/ 10L/12.5L/15L/20L/25L/ 30L/40L/50L/60L/75L/ 1Cr/2Cr/3Cr			<Double Wallet Plan/Infinity Wallet Plan/Carry Forward Sum Insured Plan/Worldwide Treatment Plan/Early Start Plan/Senior Priority Plan/ Even Protect Plan/ BharatX*>

*BharatX can be customized as per Customer's requirements

BASE COVERS (Applicable in case of BharatX)

S. No	Coverages	Opted (Yes/No)	Limits	Specific Terms and Conditions
1	**Hospitalization Cover**	Yes/No	-	
1.1	**In -Patient Hospitalization**	-	< As per Section 1 Sum Insured >	
1.2	**Day care Procedures**		NA	
1.3	**Pre-Hospitalization**	-	30/60/90/120 days *	
1.4	**Post Hospitalization**	-	60/90/120/180 days*	
1.5	**Road Ambulance**	-	1% of Sum Insured max upto INR 10,000	
1.6	**Bariatric Surgery**		NA	
1.7	**Psychiatric Illness**		NA	
1.8	**Health Check Up**		0.25% of Sum Insured max upto INR 2,000 after every year	
1.9	**Home (domiciliary) Hospitalization**		NA	
1.10	**Ayush Hospitalization**		NA	
1.11	**Daily Cash for Choosing Shared Accommodation**		i. Per Day Cash Benefit – INR _____ ii. Maximum No. of days _____	Specific Condition: Per day room rent should not be more than INR 3000/
2	**Organ Donor Expenses**	Yes/No	NA	
3	**Emergency Air Ambulance**	Yes/No	NA	
4	**Maternity Benefit Wallet & Newborn Cover**	Yes/No	Limit on Maternity Expenses of Your Second Child: _____% of the Sum Insured under this Section	
5	**Worldwide Coverage**	Yes/No	NA	
6	**Sum Insured Back Up**	Yes/No	Upto Sum Insured Unlimited Reinstatement / once in a policy period - related and unrelated illness	
7	**In-Built Personal Accident**	Yes/No	INR 50,000/ INR 1,00,000	

* Pre-hospitalization days will be always lesser than post hospitalization days

OPTIONAL COVERS (Applicable for all the Plans)

Optional cover number.	Coverage Name	Opted (Yes/No)	Limits	Terms and Conditions
1	Consumables Cover	Yes/No	<___% of Section 1 Sum Insured>	
2	Network Hospital Discount	Yes/No	< __Gold/__Silver/__Standard>	
3	Pre-existing Disease/Specific Disease/Initial Waiting Period Modification	Yes/No	a. Initial Waiting Period: _____ Days b. Pre-existing Disease: _____Months c. Specific Waiting Period: ___Months	
4	Sum Insured Multiplier	Yes/No	<2/3/4 times of Sum Insured>	
5	Health Check-up cover from Day One	Yes/No	INR: _____	Health Check up Package Opted: _____
6	Advance Care	Yes/No		
7	Support Plus	Yes/No	<0.75% of Base SI or max up to INR 3,000 per day for ICU hospitalization>	Per day amount payable _____ Maximum Number of days ____
8	Advance Heart Ambulance	Yes/No	<2% of Section 1 Base Sum insured or Max of INR 20,000 whichever is lesser>	
9	Maternity & Newborn Baby Cover	Yes/No	Limit on Maternity Expenses of Your Second Child: _____% of the Sum Insured under this Section	Pre and post-natal up to 100% of optional cover 9 SI
10	Infertility Treatment Cover	Yes/No	INR _____	
11	Daily Hospital Cash Cover	Yes/No	INR____ Per Day and Up to ___ Days	Time Excess: _____ Days

<table>
<tr><td>12</td><td>Daily Cash for accompanying an insured child</td><td>Yes/No</td><td>INR_____ Per Day & Up to ___Days</td><td></td></tr>
<tr><td>13</td><td>Loss of Income Cover</td><td>Yes/No</td><td>INR____ Per Day & Block of Days ___</td><td>Maximum number of times payable ___</td></tr>
<tr><td>14</td><td>Long Hospitalization Cash Benefit Cover</td><td>Yes/No</td><td>INR_____ & Minimum _____Days Hospitalization</td><td></td></tr>
<tr><td>15</td><td>Out-Patient Benefit Cover</td><td>Yes/No</td><td>INR _____</td><td></td></tr>
<tr><td>16</td><td>Second Medical Opinion</td><td>Yes/No</td><td></td><td></td></tr>
<tr><td>17</td><td>Smart Save</td><td>Yes/No</td><td>Capping of SI:<table><tr><td>Ailments</td><td>SI Limit</td></tr><tr><td>Eye Diseases / Cataract</td><td></td></tr><tr><td>Knee Replacement - per knee</td><td></td></tr><tr><td>Angiography</td><td></td></tr><tr><td>Angioplasty</td><td></td></tr><tr><td>All types of Hernia</td><td></td></tr><tr><td>CABG</td><td></td></tr><tr><td>Hysterectomy</td><td></td></tr><tr><td>Kidney / Bladder Stone</td><td></td></tr><tr><td>Oral Chemotherapy</td><td></td></tr><tr><td>Hip replacement</td><td></td></tr></table></td><td></td></tr>
<tr><td>18</td><td>Fast track</td><td>Yes/No</td><td></td><td>Disease/ illness/ condition covered:
1.Asthma
2.Chronic Obsutructive Pulmonary Disease (COPD)
3.Diabetes
4.Hypertension
5.Hyperlipidemia
6.Obesity
7.Coronary Artery Disease (PTCA done prior to 1 year)
8.Thyroid</td></tr>
<tr><td>19</td><td>Cumulative Bonus Protection Cover</td><td>Yes/No</td><td>INR _____ cumulative bonus protection cover amount</td><td>% of Cumulative Bonus as per base cover</td></tr>
<tr><td>20</td><td>Infinite Cumulative Bonus</td><td>Yes/No</td><td>__With/__Without claims protection</td><td>If With _____ Claim amount protection</td></tr>
<tr><td>21</td><td>Room Rent Modification Cover</td><td>Yes/No</td><td>____No Restriction/ __All rooms except suite/ ___Single Private AC room/ ___Shared Accommodation/ ___Shared Accommodation max up to 5000/ ___1% of SI*/ ___General Ward</td><td></td></tr>
<tr><td>22</td><td>NRI Benefit</td><td>Yes/No</td><td>___Discount on the premium/ __4X of base sum insured of section 1 for named illnesses</td><td>Named Illness which are covered are as follows:
• Cancer of Specified Severity
• Myocardial Infarction
• Open Heart Replacement or Repair of Heart Valves
• Surgery to Aorta
• Open Chest CABG
• End Stage Lung Failure
• End Stage Liver Failure
• Kidney Failure Requiring Regular Dialysis
• Major Organ/ Bone Marrow Transplant
• Benign Brain Tumour
• Coma of Specified Severity</td></tr>
</table>

				• Major Head Trauma • Permanent Paralysis of Limbs • Multiple Sclerosis with Persisting Symptoms
23	Policy Tenure Multiplier	Yes/No		
24	Premium Refund	Yes/No		
25	Medical Equipment Cover	Yes/No	__% of sum insured or INR ___ whichever is higher	

* 1% of Section 1 Sum insured

OTHER FEATURES (Applicable in case of BharatX)

S.No.	Features	Limits Opted	Specific Terms and Conditions
1	Carry Forward Sum Insured		
2	Initial Waiting Period	7 days/ 15 days/ 30 days	
3	Pre-existing Disease Waiting Period	3 years/2 years/1 year/9/6/3/0 months	
4	Specific Disease Waiting Period	3 years/2 years/1 year/9/6/3/0 months	

NO CLAIM BONUS

S.No.	Features	Limits Opted	Specific Terms and Conditions
1	Cumulative Bonus / No Claim Discount	(5% up to 25%), (10% up to 50%), (10% up to 100%), (20% up to 100%), (50% up to 100%), (50% up to 150%), (100% up to 200%), (100% up to 300%), (100% up to 400%), (100% up to 500%), (100% up to 600%) % / Discount on renewal premium	
2	Inflation Boost	INR _____	

DEDUCTIBLE OPTIONS (in INR)

2,500 ☐	5,000 ☐	7,500 ☐	10,000 ☐	15,000 ☐
20,000 ☐	25,000 ☐	30,000 ☐	40,000 ☐	50,000 ☐

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							

Are you enrolled in any of the corporate GMC policy: Yes/No

Special Terms and Exclusions

1.
2.

PREMIUM PAYMENT ZONE & GEOGRAPHICAL LIMITS

Premium Payment Zone: ☐ Zone 1 ☐ Zone 2

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

Zone 1: Delhi/NCR, Mumbai including (Navi Mumbai, Thane and Kalyan) and Greater Hyderabad Area.

Zone 2: Rest of India apart from Zone 1.

Note: In case of family floater policies, a single zone shall be applied to all the members covered under the policy.

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 uneventful maternity/delivery in case of female customer)		1	2	3	4	5	Up to 1	2	3	4	> 4
3	Any diagnostic tests like Blood/ECG/ECHO/CT		1	2	3	4	5	Up to 1	2	3	4	> 4

	or MRI Scan etc., in last 4 years other than preventive health check up with normal reports											
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				

NOMINEE DETAILS

Name of Insured Person	Name of Nominee	Mobile number of Nominee	E-mail Id of Nominee	Present Address of the Nominee	Permanent Address of Nominee (Not required, if same as present address)	Relationship of Nominee with Insured Person	Details of authorized person (If Nominee is minor)	Details of Bank Account of Nominee
								i. Bank a/c no. _____ ii. IFSC code _____ iii. Branch _____ iv. Bank Name _____
								i. Bank a/c no. _____ ii. IFSC code _____ iii. Branch _____ iv. Bank Name _____
								i. Bank a/c no. _____ ii. IFSC code _____ iii. Branch _____ iv. Bank Name _____

CUSTOMER BANK DETAILS

Bank Account No.	**Branch**	**IFSC Code**	**Bank Name**

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 submission document)
6. Statement of saving bank account with details of present/ present address (updated up to 1 month prior to claim submission document)