

## CORONA KAVACH POLICY, NAVI GENERAL INSURANCE LIMITED

### PROPOSAL FORM

Proposal Form Number:

URN – NAVIGICKP0720

#### GUIDELINES OF FILLING THIS PROPOSAL FORM

- 1) Please complete all sections in capitals and tick the boxes wherever applicable. Please furnish all information that is sought and is having a bearing on the risk.
- 2) Failure to disclose facts material to the assessment of the risk or providing misleading Information may render the contract void.
- 3) We shall process the proposal within a reasonable period but not exceeding 15 days from the date of receipt of proposal or any other requirement called by us.
- 4) Where a proposal deposit is refundable under any circumstances, we shall refund the same within 15 days from the date of underwriting decision on the proposal.
- 5) This Proposal Form shall be the basis of contract for Policy issuance and shall be signed by the Proposer.
- 6) We are under no obligation to accept any proposal for insurance. Our liability will commence only when this Proposal is accepted by Us (subject to the policy terms and conditions) and the premium is received and realised.

#### I. PROPOSER DETAILS

Proposer Name	: <input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms.								
Date of Birth	: <table border="1" style="display: inline-table; border-collapse: collapse; text-align: center;"> <tr> <td style="width: 20px;">D</td> <td style="width: 20px;">D</td> <td style="width: 20px;">M</td> <td style="width: 20px;">M</td> <td style="width: 20px;">Y</td> <td style="width: 20px;">Y</td> </tr> </table>	D	D	M	M	Y	Y	Marital Status	: <input type="checkbox"/> Married <input type="checkbox"/> Unmarried <input type="checkbox"/> Others
D	D	M	M	Y	Y				
Gender	: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender	E-mail Id	: _____						
Occupation	: <input type="checkbox"/> Student <input type="checkbox"/> Self Employed <input type="checkbox"/> Salaried <input type="checkbox"/> House Wife <input type="checkbox"/> Retired <input type="checkbox"/> Others (please specify) : _____								
Aadhar Number	: _____								
PAN Number	: _____	(Mandatory for premium of ₹ 50,000 and above)							
SEZ Holder	: <input type="checkbox"/> Yes <input type="checkbox"/> No	GSTIN	: _____						
Address	: _____								
(Note – This address shall be taken for GST Computation)	Landmark : _____	City / Town	: _____						
	District : _____	Pin Code	: _____						
	Telephone No. : _____	Mobile No.	: _____						

I hereby consent that the Policy Documents shall be sent to me by e-mail only on my registered e-mail Id. I understand that this authorisation can be revoked by me at the time of renewal by contacting your branch office personally or customer care by writing a mail/ calling your toll-free number.

#### II. PLAN DETAILS – Please select the required plan and Sum Insured

Tenure	: 3.5 months <input type="checkbox"/> 6.5 months <input type="checkbox"/> 9.5 months <input type="checkbox"/>														
Proposed Policy Period	: From : <table border="1" style="display: inline-table; border-collapse: collapse; text-align: center;"> <tr> <td style="width: 20px;">D</td> <td style="width: 20px;">D</td> <td style="width: 20px;">M</td> <td style="width: 20px;">M</td> <td style="width: 20px;">Y</td> <td style="width: 20px;">Y</td> </tr> </table> To : <table border="1" style="display: inline-table; border-collapse: collapse; text-align: center;"> <tr> <td style="width: 20px;">D</td> <td style="width: 20px;">D</td> <td style="width: 20px;">M</td> <td style="width: 20px;">M</td> <td style="width: 20px;">Y</td> <td style="width: 20px;">Y</td> </tr> </table>	D	D	M	M	Y	Y	D	D	M	M	Y	Y		
D	D	M	M	Y	Y										
D	D	M	M	Y	Y										
Sum Insured Type	: <input type="checkbox"/> Non-Floater <input type="checkbox"/> Family Floater														

#### III. PROPOSED INSURED DETAILS

Sr. No.	Name	Gender* (M/F/T)	Date of Birth (DD/MM/YYYY)#	Relationship with Proposer**	Sum Insured ***
1	Insured 1				
2	Insured 2				
3	Insured 3				
4	Insured 4				
5	Insured 5				

\*M = Male / F = Female / T = Transgender

# Age should be from Day 1 – 65 years only

\*\*Allowed relations are Spouse, dependent children (3 months to 25 yrs), parents and parents in law.

\*\*\*Sum Insured available are – Minimum ₹ 50,000 . Thereafter, in multiples of ₹ 50,000 upto ₹ 5 Lakhs.

### Navi General Insurance Limited

(Formerly known as DHFL General Insurance Limited)

Corona Kavach Policy, Navi General Insurance Limited | UIN : NAVHLIP21077V012021

Registered &amp; Corporate Office : 402, 403 &amp; 404, A &amp; B Wing, 4th Floor, Fulcrum, Sahar Road, Next to Hyatt Regency, Andheri (East), Mumbai - 400 099.

Toll Free: 1800-123-0004 | Fax : 022-4001 8251 | Website : www.cocogeneralinsurance.com | Email : mycare@cocogeneralinsurance.com

CIN : U66000MH2016PLC283275 | IRDAI Registration Number : 155

IV. NOMINEE DETAILS		
In the event of the death of the Policyholder, any payment due under the Policy shall become payable to the Nominee in accordance with the Policy terms and conditions. The nominee must be an immediate relative of the Proposer. Nominee for persons proposed to be insured shall be the Proposer himself/herself.		
Nominee Name	Date of Birth	Relationship with Proposer
If Nominee is minor, please give the name and address of the appointee and relationship with the minor		
Appointee Name	Date of Birth	Relationship with Minor

V. MEDICAL AND HEALTH INFORMATION						
Please answer the below mentioned questions individually in Yes(Y) / No (N) in the relevant box You must answer the questions truthfully. Not doing so would lead to termination of your policy.						
DISCLOSURE OF DISEASE/ILLNESS						
		Insured 1	Insured 2	Insured 3	Insured 4	Insured 5
1	Are you suffering from any of the following disease(s) –	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	If Yes, please tick the disease -					
	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Hypertension	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Myocardial Infarction (Heart Attack) / Cardiomyopathy (Heart Failure) Or any other Heart related ailment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Cancer of any type	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Stroke (Cerebro Vascular Accident)	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Thalassemia/ Leukaemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Any Respiratory disorder- Asthma, Chronic Obstructive Pulmonary Disease, Interstitial Lung disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	HIV/ AIDS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	End Stage Organ Failure (Liver/ Lung/ Kidney)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Recipient in Organ Transplant Surgery	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Any major surgery in last 15 days	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2	Are you currently suffering from Cough/ Fever/ Fatigue/ Loss of Taste or Smell/ Breathlessness/ Sore Throat/ loose Stools/ Abdominal Pain / Covid 19?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
3	Were you diagnosed with COVID positive infection in the past but completely recovered now?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

VI. OTHER INFORMATION						
		Insured 1	Insured 2	Insured 3	Insured 4	Insured 5
1	Are you dependent on Public Transport for daily commute in relation to office work or business?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
2	Are you in direct contact or living with the person who is recently confirmed as COVID positive?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	If Yes - Are you a healthcare worker, engaged in management of patients at healthcare facility?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

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Toll Free: 1800-123-0004 | Fax : 022-4001 8251 | Website : [www.cocogeneralinsurance.com](http://www.cocogeneralinsurance.com) | Email : [mycare@cocogeneralinsurance.com](mailto:mycare@cocogeneralinsurance.com)  
CIN : U66000MH2016PLC283275 | IRDAI Registration Number : 155

3	Is your residence within 50kms of domestic or international airport?	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
		<input type="checkbox"/> No	<input type="checkbox"/> No	<input type="checkbox"/> No	<input type="checkbox"/> No	<input type="checkbox"/> No
4	Have you returned from overseas trip within past 15 days?	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
		<input type="checkbox"/> No	<input type="checkbox"/> No	<input type="checkbox"/> No	<input type="checkbox"/> No	<input type="checkbox"/> No

#### VII. PREMIUM PAYMENT AND BANK DETAILS

For Cheque/DD/PO (Payable in favour of Navi General Insurance Limited)

Payment Option: Cheque  Demand Draft  Fund Transfer  Pay Order   
 Debit Card  Credit Card

Payment Frequency: Monthly  Quarterly  Half Yearly  Annual

As per the Regulatory requirements, we can affect payment of the refund (if any) and or claims only through Electronic Clearing System (ECS) / National Electronic Funds Transfer (NEFT) / Real Time Gross Settlement (RTGS) / Interbank Mobile Payment Service (IMPS).

For this purpose, please submit the following details of the Proposer's bank account.

Account Holder Name : \_\_\_\_\_

Instrument Number : \_\_\_\_\_ Instrument Date : \_\_\_\_\_

Instrument Amount : \_\_\_\_\_ Bank Name : \_\_\_\_\_

Credit/Debit Card No. : \_\_\_\_\_ Expiry Date : \_\_\_\_\_

Account No. : \_\_\_\_\_ IFSC/MICR Code : \_\_\_\_\_

UPI ID : \_\_\_\_\_

Type of Account : Saving Bank's Account  Current Account   
 Others (Please Specify)  \_\_\_\_\_

Note – If the Premium cheque is not paid from the above-mentioned account then a cancelled cheque leaf of the above-mentioned account is to be attached. Mandatory if annualized premium is more than ₹.25,000.

#### VIII ELECTRONIC INSURANCE ACCOUNT DETAILS OF PROPOSER

(Email Id is mandatory)

Do you have an EIA :  Yes  No If No, do you wish to apply for EIA :  Yes  No

If Yes, please quote the EIA number : <<\_\_\_\_\_>>

If applied, please mention your preferred Insurance Repository : <<\_\_\_\_\_>>

Email Id (Registered with Insurance Repository) : <<\_\_\_\_\_>>

Your Policy will be credited in your EIA account and your address details as mentioned in the EIA shall override the address provided in this proposal for Insurance. We request you to inform the Repository of any changes in the details immediately.

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IX. DECLARATION	
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 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 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 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."
Date: _____ Place: _____ Signature of Proposer _____	

X. OTHER DECLARATIONS	
<input type="checkbox"/>	Any GST liability and payment for the same is dependent on the details (viz GSTIN, address, zero-rating entitlement etc) provided by me. Navi General Insurance Limited will rely on such information for the purpose of compliance with applicable GST regulations and shall not be under obligation to evaluate authenticity/accuracy of the same. Further, in case any GST liability (in terms of tax, interest, penalty and associated litigation cost) arises on Navi General Insurance Limited on account of any incorrect/ incomplete/ non-compliance on behalf of me. I will be immediately liable to pay the same on notification by Navi General Insurance Limited. The said liability shall vest irrespective of the completion of the insurance period covered within the policy contract.
<input type="checkbox"/>	I hereby consent to and authorize Navi General Insurance Limited to make welcome calls, service calls or any other communication (electronic or otherwise) with respect to the proposed or existing policy of the Company from time to time.
<input type="checkbox"/>	I/We hereby confirm that all premiums have been/will be paid from bonafide sources and no premiums have been/will be paid out of proceeds of crime related to any of the offence listed in Prevention of Money Laundering Act, 2002. I understand that the Company has the right to call for documents to establish sources of funds. The insurance company has right to cancel the insurance contract in case I am/have been found guilty by any competent court of law under any of the statutes, directly or indirectly governing the prevention of money laundering in India.

XI. VERNACULAR DECLARATION	
I hereby declare that, I have fully explained the contents of the Proposal Form and terms and conditions of the Policy to the Proposer in the language understood to him/her.	
Signature/Thumb Impression of the Proposer: _____	
Name of Witness: _____	Signature of Witness: _____
Date: _____	Place: _____

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**XII. INTERMEDIARY DECLARATION**

I, \_\_\_\_\_ (Full Name), in my capacity as an Insurance Agent/Insurance Intermediary, 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 (Insurance Agent / Insurance Intermediary) : \_\_\_\_\_

Date: \_\_\_\_\_ Place: \_\_\_\_\_ Signature of Insurance Agent / Intermediary : \_\_\_\_\_

**Prohibition of Rebates: Section 41 of the Insurance Act, 1938 (and amendments thereof)**

- 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 ten lakh rupees.

**INTERMEDIARY DETAILS (FOR OFFICE USE ONLY)**

Branch Office	:	_____	Intermediary Code	:	_____
Branch Code	:	_____	Intermediary Name	:	_____
Business Sector	:	Urban/Rural/Social	Intermediary contact Number	:	_____

**ACKNOWLEDGE SLIP**

Proposal form received from: Mr./Mrs./Ms \_\_\_\_\_

Address: \_\_\_\_\_ Premium amount: ₹ \_\_\_\_\_ To be debited from \_\_\_\_\_

Account of Mr./Ms \_\_\_\_\_ Account Number: \_\_\_\_\_ Bank Name: \_\_\_\_\_

Cheque Number: \_\_\_\_\_ Date: \_\_\_\_\_ Branch: \_\_\_\_\_

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