

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 : Mr. Mrs. Ms.

Date of Birth :

D	D	M	M	Y	Y
---	---	---	---	---	---

 Marital Status : Married Unmarried Others

Gender : Male Female Transgender E-mail Id : _____

Occupation : Student Self Employed Salaried House Wife Retired
 Others (please specify) : _____

Aadhar Number : _____

PAN Number : _____ (Mandatory for premium of ₹ 50,000 and above)

SEZ Holder : Yes 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 6.5 months 9.5 months

Proposed Policy Period : From :

D	D	M	M	Y	Y
---	---	---	---	---	---

 To :

D	D	M	M	Y	Y
---	---	---	---	---	---

Sum Insured Type : Non-Floater 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.

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

Registered & Corporate Office: Navi General Insurance Limited
402, 403 & 404, A & B Wing, 4th Floor, Fulcrum, Sahar Road, Next to Hyatt Regency, Andheri (E), Mumbai -400099
Toll-free number: 1800 123 0004 8200 | Fax: 022-4001 8251 | Website: www.naviinsurance.com | Email: mycare@navi.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

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

Registered & Corporate Office: Navi General Insurance Limited
 402, 403 & 404, A & B Wing, 4th Floor, Fulcrum, Sahar Road, Next to Hyatt Regency, Andheri (E), Mumbai -400099
 Toll-free number: 1800 123 0004 8200 | Fax: 022-4001 8251 | Website: www.naviinsurance.com | Email: mycare@navi.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 <input type="checkbox"/> Demand Draft <input type="checkbox"/> Fund Transfer <input type="checkbox"/> Pay Order <input type="checkbox"/> Debit Card <input type="checkbox"/> Credit Card <input type="checkbox"/>
Payment Frequency:	Monthly <input type="checkbox"/> Quarterly <input type="checkbox"/> Half Yearly <input type="checkbox"/> Annual <input type="checkbox"/>
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 <input type="checkbox"/> Current Account <input type="checkbox"/> Others (Please Specify) <input type="checkbox"/> _____
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	: <input type="checkbox"/> Yes <input type="checkbox"/> No
If No, do you wish to apply for EIA	: <input type="checkbox"/> Yes <input type="checkbox"/> 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.	

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: _____

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: _____