INDIVIDUAL PERSONAL ACCIDENT POLICY (Accidental Death & Disablement only)



Proposal No.

	FOR OFFICI	E USE ONLY	
Branch Name:			Branch Code:
Intermediary: 🗌 Agency 🗌 Direc	ct \square Corporate Agency \square Other Interm	ediaries	
Intermediaries Name:			Intermediary Code:
Proposal Received On:			
Processed By:	Date D D M M Y Y Y Y	Approved By:	Date D D M M Y Y Y Y
Customer ID:			

GUIDELINES FOR COMPLETION OF THE FORM (TO BE FILLED BY PROPOSER/REPRESENTATIVE)

- Please answer all the questions fully and correctly.
- This proposal will be the basis of any insurance policy that We may issue.
- You must disclose all facts relevant to all persons proposed to be insured that may affect our decision to issue a policy or its price, terms, conditions and exclusions.
- The policy shall become void at our sole discretion, in the event of any untrue or incorrect statement, misrepresentation, non-description or non-disclosure in any material particular in the proposal form/personal statement, declaration and connected documents or any material information having been withheld by the Proposer or any one acting on his behalf.
- If there is insufficient space for you to provide information whether as requested or otherwise, please attach a separate sheet.
- If you are in any doubt, please seek the help of our company representative or your insurance advisor.
- If We accept a proposal for insurance, it shall be subject to the Policy terms and conditions and We shall have no liability to make any payment under the Policy if premium is not received by Us in full and in time, or is not realized or non-fulfilment of pre-policy medical check-up.
- Please fill up this form in CAPITAL LETTERS for yourself and each proposed Insured Person.
- A policyholder or prospect who is a person with disability and requires assistance in completing the proposal form, may duly authorize a representative to give declaration on his/her behalf.

		PR	OPOSER DETA	alls				
Mr. Mrs. Mis	s 🗌 Others	Gender Male	Female 3 rd	Gender				
PAN Number	Aadhaar No.							
Name of the Proposer	First Name		Middle N	ame		Last Name		
Permanent Address								
(As per address proof)								
	City			State				
Landmark					Pir	ncode		
Telephone		Mobile*						
Current Address (if diff	erent from Permanen	t Address)						
	Same as permane	ent address						
	City			State				
Landmark					Pir	ncode		
Telephone		Mobile*						
UIN: IRDAI/NL-HLT/RSAI/P-H	/V.I/215/13-14		1		Individual Personal Ac	cident Policy Form PR24213/MAR25		

Education Qualification Lesser than matriculation Matriculation Graduate Post Graduate Professional Course Occupation Salaried Self employed Student House wife Others
Occupation Salaried Self employed Student House wife Others
If salaried, specify designation
If self employed, specify business/occupation
Annual Gross Income (₹) 🗌 Up to 5 lakhs 🗌 5 to 10 Lakhs 🗌 10 to 25 Lakhs 🗌 26 to 50 lakhs 🗍 50 Lakhs to 1 Crore 🗌 Above 1 Crore
E-mail*
Ayushman Bharat Health Account (ABHA)
*Please provide ABHA number (Ayushman Bharat Health Account number) for all the proposed Insured Persons. In case the ABHA number is not available for any Insured Person, you may request to create an ABHA number by visiting the web link: https://abha.abdm.gov.in/abha/v3/register
e-IA Number (Electronic Insurance Account Number)
Would you like to open an Electronic Insurance Account with any Insurance Repository? 🗌 YES 🗌 NO
If yes, please furnish the below details.*
Insurance Repository Name Account will be opened with your Name / DOB / Address as mentioned in this proposal form.
If you already have an Electronic Insurance Account, please share the below details
Account Number
Account Name
Insurance Repository Name
Please specify if you fall under any of the listed categories. (please tick and give details where ever required) 1. Non Resident Indian (NRI) 2. State for The second state of the seco
 2. Member of any Trust: Charities Non-Government Organisation (NGO) 3. Politically Exposed Person (PEP): Senior Politician Senior Government Judicial Military Officer
Senior Executive of State Owned Corporation
☐ Head of State or of Government.
KNOW YOUR CUSTOMER (KYC) DETAILS
Please provide your Central Know Your Customer registration number below.
Please provide your Central Know Your Customer registration number below.
Please provide your Central Know Your Customer registration number below. CKYC Number
Please provide your Central Know Your Customer registration number below. CKYC Number
Please provide your Central Know Your Customer registration number below. CKYC Number Image:
Please provide your Central Know Your Customer registration number below. CKYC Number
Please provide your Central Know Your Customer registration number below. CKYC Number
Please provide your Central Know Your Customer registration number below. CKYC Number
Please provide your Central Know Your Customer registration number below. CKYC Number Image:
Please provide your Central Know Your Customer registration number below. CKYC Number Image:
Please provide your Central Know Your Customer registration number below. CKYC Number Image:
Please provide your Central Know Your Customer registration number below. CKYC Number Marital Status Single Married Widow/Widower Divorced Nationality Occupation Service Self Employed Others: Are you an existing Royal Sundaram customer?* YES YES NO *If yes, please provide Existing Policy No. Image: Confirm below on the documents being shared by you (proposer) to comply with KYC guidelines. (Please tick) 1. PAN Card Copy (compulsory) 2. Form 60 (only if PAN is not available) 3. Address Proof Driving License Voter's Identity Card Passport Copy NREGA Card

DETAILS OF PERSONS TO BE COVERED

Sl. No	Insured Name (First, Middle, Last)	Gender: Male (M)/Female (F)/ Others (O)	ABHA No.	Date of birth (DD/MM/YYYY)	Relationship with proposer	Height (cm)	Weight (kg)	Occupation	Annual Income (if applicable)
1.		M F O							
2.		MFO							
3.		MFO							
4.		MFO							
5.		M F O							
6.		MFO							

*Please choose the relationship with proposer from this list - Spouse as long as he or she continues to be married to you, Son, Daughter-in-law, Daughter, Father, Mother, Father-in-law as long as your spouse continues to be married to you, Grandfather, Grandmother, Grandson, Granddaughter, Sonin-law, Brother, Sister-in-law, Brother-in-law, Brother-

Please choose the occupation from this list - Salaried, Self Employed, Housewife, Student, Others.

Note: Please enter the details of additional members in excess of 6 in the additional sheet attached at the end of this form.

COVERAGE SELECTION

1. Plan details	Policy Ty	ype: 🗌 Individual 🗌 Family
2. Proposed policy term		Policy Tenure: 1 Year 2 Years 3 Years
3. Sum Insured		

Please provide coverage details in below table (Please do not fill anything in Premium Computation Column):

S. No	Insured Name (First, Last)	Individual Sum	Insured Option	Premium	Final Premium (inclusive of GST*)	
3. NO		Plan	Sum Insured	Computation (for office use only)		

* Note: The premiums for respective Zones will be based on Proposer's residence/ pin code/ zone. Please note the Cities/ Towns that fall under respective Zones shall be identified as per the updated/ latest Jurisdiction defined.

Cover	Details	Please select
Accidental Death	100% of Sum Insured	
Permanent Total Disablement	Up to 100% of Sum Insured	
Permanent Partial Disablement	% as per Schedule	
Temporary Total Disablement	Temporary Total Disablement 1% of CSI up to 100 weeks with weekly benefit of maximum of 3000/-	
Medical Expenses	Actuals or 40% of Claim Amount or 10%, of sum insured whichever is less	

POLICY DOCUMENTS DELIVERY PREFERENCE (Please select your preferred mode of receiving the policy documents):

Electronic Copy only (via registered email/mobile number)

□ Both Electronic & Physical Copies*

*Note: If you select both electronic and physical copies, the physical copy will be dispatched to your registered mailing address.

NOMINATION

In the event of the death of the proposer any payment due under the policy shall become payable to the nominee proposed in the form. The receipt of the proceeds by such nominee would be sufficient discharge to the company. Nominee for all other persons proposed to be insured shall be the proposer himself/herself. Nomination can be changed at any time during the term of the policy. Following section to be filled by the Proposer/Representative:

Nominee Name** (First, Last)	Relationship with the proposer	Address and contact details of Nominee	% of Sum Insured	Bank Account details of the Nominee
		Present Address		1. Account No.
		Permanent Address		2. IFSC Code 3. Bank Name
		Phone Number		4. Branch Name
		Email ID		5. Branch Code

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Nominee Name** (First, Last)	Relationship with the proposer	Address and contact details of Nominee	% of Sum Insured	Bank Account details of the Nominee
		Present Address		1. Account No.
		Permanent Address		2. IFSC Code
		Phone Number		3. Bank Name 4. Branch Name
		Email ID		5. Branch Code
		Present Address		1. Account No.
		Permanent Address		2. IFSC Code
		Phone Number		3. Bank Name 4. Branch Name
		Email ID		5. Branch Code
		Present Address		1. Account No.
		Permanent Address		2. IFSC Code
		Phone Number		3. Bank Name 4. Branch Name
		Email ID		5. Branch Code

**Nominee for Primary insured/ Proposer may to be among the following mentioned relations

☐ Father ☐ Mother ☐ Son ☐ Daughter ☐ Spouse

In case the nominee is a minor then please provide the name and address of the Appointee -

Name of the Appointee	Name and address of the Appointee	Relationship with the Nominee	Age	Contact Number

MEDICAL QUESTIONS

(Yes/No response is mandatory for each of the questions. Any other response will be treated as a non-submission. You must answer these questions truthfully)

Please answer the below mentioned questions accurately to the best your knowledge in respect of each person proposed to be insured. If the answer to any of these questions is Yes, please provide the complete details in the table for additional medical information.

Please ensure that you are fully informed about the standard waiting periods and permanent exclusions that apply to the Individual Personal Accident Policy.

Sl. No	Details	Insured 1	Insured 2	Insured 3	Insured 4
1	Are you in good health and not suffering from any disease currently	YES NO	YES NO	YES NO	YES NO
2	If response to question 1 is No, please provide details	YES NO	YES NO	YES NO	YES NO
3	Are you taking any treatment or medicines currently	YES NO	YES NO	YES NO	YES NO
4	If response to question 3 is yes, please provide details	YES NO	YES NO	YES NO	YES NO
5	Have you been admitted to hospital in the past	YES NO	YES NO	YES NO	YES NO
6	If response to question 5 is yes, please provide details	YES NO	YES NO	YES NO	YES NO
7	Do you have have any physical defect, deformity or disability	YES NO	YES NO	YES NO	YES NO
8	If response to question 7 is yes, please provide details	YES NO	YES NO	YES NO	YES NO
9	Do you have any history of any major accidents in the past or any birth defect causing a reduced functionality	YES NO	YES NO	YES NO	YES NO
10	If response to question 9 is yes, please provide details	YES NO	YES NO	YES NO	YES NO
11	Are you dependent on another person to perform all your routine activities	YES NO	YES NO	YES NO	YES NO
12	If response to question 11 is yes, please provide details	YES NO	YES NO	YES NO	YES NO

OTHER ONGOING HEALTH INSURANCE / PERSONAL ACCIDENT / CRITICAL ILLNESS POLICY INFORMATION (including those obtained from Royal Sundaram General Insurance Co. Limited)

Sl. No	Name of Insured	Name and Address of insurance company	ddress of Policy No.	Period of Insurance first inception date	Period of	Period of Insurance Sum clai Insured (₹) rev		Claim details, claim amount received or receivable (in ₹)	Are any persons to be insured opting for portability or migration form
					From	То			migration from an existing cover?
1.					D D M M Y Y Y Y	D D M M Y Y Y Y			YES NO
2.					D D M M Y Y Y Y	DDMMYYYY			YES NO

*Note: In case of Portability/ Migration, kindly fill Portability/ Migration Request form along with this form

AUTHORIZATION FOR ELECTRONIC POLICY FULFILLMENT AND SERVICE COMMUNICATIONS (Please read carefully and put a check mark against each before signing)

I hereby consent that the policy documents may be sent to me by email_	
WhatsApp at	

□ I hereby consent to and authorize Royal Sundaram General Insurance Co. Limited (Company) to make welcome calls, service calls or any other communication (electronic or otherwise) with respect to the proposed or existing policy of Company from time to time.

Date : D D M M Y Y Y Y

Signature of the Proposer / Representative : _____

Place : _

Name of Proposer : _____

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 authorized 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.
- 6. I declare that the premium amount, corresponding to this proposal, is paid out of the legally declared and assessed sources of my income and not out of proceeds of crime related to any Offence under the Prevention of Money Laundering Act, 2002 and rules framed thereunder. I understand that Royal Sundaram reserves the right to call for documents and information to establish the source of funds, as also the right to reject the said proposal or to terminate the insurance contract unilaterally and/or forfeit the premium amount, if I am found to be named in any recognized sanction list/happen to have violated any provisions of law.
- 7. I confirm that the premium has been paid by ______, who has an insurable interest in my policy and refund, if any, shall be processed in my bank account.
- 8. I am (please tick all that are applicable): 🗌 HNI 🗌 NRI 📄 Politically Exposed Person 📄 Jeweller 📄 NGO 📄 Film Actor 📄 Producer 📄 Others.
- 9. ABHA Declaration (Applicable only if you have shared the ABHA number with Us) I, hereby declare that I am voluntarily sharing Ayushman Bharat Health Account number (ABHA No) for the proposed Insured Persons, with Royal Sundaram, for the sole purpose of accessing my records of medical history, which will be used to verify/share relevant information provided herein on confidential basis within its Group and /or third party agencies in connection with the Claims, for the purpose of facilitating insurance/ reinsurance services and ancillary services.
- 10. I consent to the fact that Royal Sundaram may download my/proposer's CKYC record from the Central KYC Records Registry, in relation to the verification of my/proposer's KYC records as part of this proposal. I understand that acceptable officially valid documents shall be relied upon for the said verification of KYC records. I, also, consent to receive information from the Central KYC Registry through SMS/email on the above-mentioned mobile phone number/email address. It is, also, confirmed that the KYC records available in the CKYC Registry are current and valid, as on the date of this proposal, and can be used by Royal Sundaram hereafter. In case of any modification, the applicable information will be provided to Royal Sundaram for updating the CKYC Registry Records.
- 11. I further confirm that I have read and understood the contents of this proposal form, including the terms, conditions, and disclosures provided by the insurer. I have been given an opportunity to seek clarifications, and I am fully aware of the implications of the coverage, premium payments, and policy terms.

Date : D D M M Y Y Y Y

Signature of the Proposer/Representative : _____

Place :

Name of Proposer :

AUTHORIZATION FOR REPRESENTATIVE (for Persons With Disability Requiring As I,, hereby authorize																																									
proposer:) to complete this proposal for																																`				-					
information provided	is acc	urat	te ar	nd g	iven	1 W	ith	my	7 ful	l co	onse	ent.																													
Contact Number of Authorized Representative:												-		Si	gna	atu	re c	of A	uth	oriz	zed	Rej	pre	sen	tativ	ve:															
Date: $D D M M Y Y Y Y$																																									
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VERNACULAR DECL The terms, conditions me in my preferred la language(dialect) bef	, and nguag	ben ge(d	efits ialeo	ct) ł	oy tł	he p	pers	sor	1s. A				-	-			-					-						-	-			-						-			
Declarants Name																																									
Relationship with proposer																																									
Date : DDMM	ate : DDMMYYYYY Signature of the Proposer/Representative: ace : Name of Proposer :																																								
Place :															Nai	me	of	Pro	ро	ser	:																				
Witness Name:														Ι	nt	erm	edi	iary	//	Age	nt	Nan	ne:																		
Witness Signature:	Witness Signature:														Intermediary / Agent Signature:																										
POSP Name:													POSP Code:																												
POSP PAN No.:													Date and Place:																												
PAYMENT DETAILS (ASBA Bank Account (For blocking the prer ASBA Bank Name	Detai	ils		, .						acil	ity)																														
ASBA Bank A/c. No.																		IFSC/MICR Code																							
Branch Name														 							,		1																		
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INTERMEDIARY DECLARATION

_(Full Name) in my capacity as an

Insurance Advisor/Specified Person of the Corporate Agent/Authorized employee of the Broker/Relationship Officer, 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 responses(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 furthermore, 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 premium paid under the Policy may be forfeited to the Company.

License No./ID:__

L

(Advisor/Corporate Agent/Broker/Relationship Officer)

Date : D D M M Y Y Y Y

Signature of the Insurance Advisor : _____

SECTION 41 OF THE INSURANCE ACT, 1938 - PROHIBITION OF REBATES

- 1. 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 continuing the policy accept any rebate except such rebate as may be allowed in accordance with the published prospectus or tables of the Insurer.
- 2. If any person fails to comply with sub-regulation (1) above, he shall be liable to payment of a fine which may extend to Ten Lakh Rupees.



Royal Sundaram General Insurance Co. Limited

Vishranthi Melaram Towers, No. 2 / 319, Rajiv Gandhi Salai (OMR), Karapakkam, Chennai - 600097. Registered Office: 21, Patullos Road, Chennai - 600 002. Royal Sundaram IRDAI Registration No.102 | CIN:U67200TN2000PLC045611

🐧 1860 425 0000 | 🖂 care@royalsundaram.in | 肴 www.royalsundaram.in

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INDIVIDUAL PERSONAL ACCIDENT POLICY (Accidental Death & Disablement only)



Proposal No.

ACKNOWLEDGEMENT

Date D D M M Y Y Y

We acknowledge with thanks the receipt of your insurance proposal. Please note that under the ASBA facility, an amount of Rs. has been blocked in the ASBA account on _ _____ as per the details provided. The mere submission of this proposal or blocking of funds does not obligate us to issue a policy, which decision is and always shall be in out sole and absolute discretion. If we accept the proposal, the premium amount will be debited, and the policy will be issued subject to its terms and conditions. We shall have no liability whatsoever if premium is not received by us in full and in time or is not realized. I we do not accept the proposal, we will inform you and refund the payment, if any, received from you without interest.

Signature of the receiver and office seal



Royal Sundaram General Insurance Co. Limited Vishranthi Melaram Towers, No. 2 / 319, Rajiv Gandhi Salai (OMR), Karapakkam, Chennai - 600097. Registered Office: 21, Patullos Road, Chennai - 600 002. Royal Sundaram IRDAI Registration No.102 | CIN:U67200TN2000PLC045611

🕼 1860 425 0000 | 🖂 care@royalsundaram.in | 🖓 www.royalsundaram.in



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