

Digit Health Care Plus Policy
Proposal Form
UIN: GODHLIP21013V032223

- 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.
- 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.
- 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.
- Please submit KYC document
- 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](mailto:hello@godigit.com) 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		
		First Policy Inception Date	DD/MM/YYYY		
Email ID		*Period of Insurance	From	DDMMYYYY	00:01 Midnight
Government ID Proof					
Partner Code and Name			To	DDMMYYYY	00:01 Midnight
Partner Contact and Email ID		Policy Type	Individual / Floater		
ABHA ID (If applicable)		Family Composition			

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

DETAILS OF PERSONS TO BE INSURED

Memb er. No.	Full Na me	Relations hip with Proposer	Date of Birth (DD/MM/ YY)	Ag e	Gend er (M/F)	Heig ht	Weig ht	Occupati on	ABHA ID	Nominee/Assig nee Name	Nominee/Assignee Relationship with Insured
1											
2											
3											
4											
5											

COVERAGE DETAILS

Section with Benefits	Sum Insured (INR)	Limits	Waiting Periods	Deductible (INR) / Co-Payment (%)	Specific Conditions
SECTION 1-HOSPITALIZATION COVER					
A. Accidental Hospitalization Cover	INR	Accommodation/Room Rent: _____% of Section 1.A Sum Insured	NA		
A1. Day Care Procedures	*Inbuilt	NA			
A2. Pre-Hospitalization Expenses	*Inbuilt	Up to _____ Days			
A3. Post-Hospitalization Expenses	*Inbuilt	Up to _____ Days OR Onetime Lumpsum Benefit: _____% of the Claim Amount Approved under Section 1. A.			
A4. Dental Treatment	*Inbuilt	NA			
A5. Road Ambulance	*Inbuilt	1% of Section 1.A Sum Insured Max up to the INR 5000			
A6. Second Medical Opinion	*Inbuilt	NA			
CUMULATIVE BONUS	INR				
B. Accidental & Illness Hospitalization Cover	INR	Accommodation/Room Rent: _____% of Section 1.B Sum Insured	A. Initial Waiting Period: _____ Days		
B1. Day Care Procedures	**Inbuilt	NA			
B2. Pre-Hospitalization Expenses	**Inbuilt	Up to _____ Days			

B3. Post-Hospitalization Expenses	**Inbuilt	Up to _____ Days OR Onetime Lumpsum Benefit: _____ % of the Claim Amount Approved under Section 1. B.	B. Pre-existing Disease: _____ Mont		
B4. Dental Treatment	**Inbuilt	NA	hs		
B5. Road Ambulance	**Inbuilt	1% of Section 1.B Sum Insured Max up to the INR 5000	C. Specific Waiting Period: _____ Mont		
B6. Bariatric Surgery Cover	**Inbuilt	_____ % of Section 1.B Sum Insured	hs		
B7. Psychiatric Illness Cover	**Inbuilt	NA			
B8. 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			
B9. Second Medical Opinion	*Inbuilt	NA			
CUMULATIVE BONUS	INR _____				
SECTION 2. INFERTILITY TREATMENT COVER	**Inbuilt	10% of the Section 1.B Sum Insured	_____ Months		
SECTION 3. ORGAN DONOR	**Inbuilt	NA	As mentioned under Section 1. B.		
SECTION 4. ALTERNATE TREATMENT (AYUSH) COVER (MANDATORY IN BUILT COVER IN SECTION 1 HOSPITALIZATION COVER)	**Inbuilt	NA	As mentioned under Section 1. B.		
SECTION 5. EMERGENCY AIR AMBULANCE	*Inbuilt and/or **Inbuilt	NA	NA		
SECTION 6. LONG HOSPITALIZATION CASH BENEFIT	INR	Minimum _____ Days Hospitalization	-		
SECTION 7. MATERNITY BENEFIT & NEW BORN BABY COVER	INR	Limit on Maternity Expenses of Your Second Child: _____ % of the Sum Insured under this Section	_____ 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 Basis 2: Nil Co-payment	
SECTION 9. HOME (DOMICILIARY) HOSPITALIZATION	**Inbuilt	NA	As mentioned under Section 1. A. and/or Section 1. B.		
SECTION 10. SUM INSURED REFILL BENEFIT	Yes/No	Once During Policy Period / Unlimited Times	NA		
SECTION 11. DAILY HOSPITAL CASH COVER					
A. Accidental Hospitalization Cover	INR _____ Per Day	Up to _____ Days	NA		Time Excess: _____ Days
B. Accidental & Illness Hospitalization Cover	INR _____ Per Day	Up to _____ Days	Initial Waiting Period: _____ Days Pre-existing Disease: _____ Mont hs Specific Waiting Period: _____ Mont hs		Time Excess: _____ Days
SECTION 12. CRITICAL ILLNESS BENEFIT COVER	INR	NA	Initial Waiting Period: _____ Days		
SECTION 13. CRITICAL ILLNESS HOSPITALIZATION COVER	INR	Accommodation/Room Rent: _____ % of Section 13 Sum Insured	Initial Waiting Period: _____ Days		
CUMULATIVE BONUS	INR _____				

SECTION 14. CANCER BENEFIT COVER	INR	NA	Initial Waiting Period: ____ Days		
SECTION 15. CANCER HOSPITALIZATION COVER	INR	Accommodation/Room Rent: ____% of Section 15 Sum Insured	Initial Waiting Period: ____ Days		
CUMULATIVE BONUS	INR _____				
SECTION 16. WELLNESS BENEFIT PROGRAM	NA	Services Opted: Doctor On Call / Wellness Coach / Lab Services (Home Collection) Etc			
Optional Covers					
Section with Benefits	Sum Insured (INR)	Limits	Waiting Periods	Deductible (INR) / Co-Payment (%)	Specific Conditions
1. Payment of Non - Medical Expenses	*Inbuilt and/or **Inbuilt	____ Up to % of Approved Claim Amount / Actual Non-medical expenses whichever is lower	Same as Base Cover	Same as Base Cover	-
2. Daily Cash for accompanying an Insured Child	INR _____	No. of days _____			-
3. Loss of Income Cover	INR _____	Block of days _____			Maximum number of times payable
4. Cumulative Bonus Protection Cover	Yes/No	INR _____ Aggregate Claim amount	-	-	% of Cumulative Bonus as per base cover
5. Unused Sum Insured Benefit	Yes/No	-	-	-	-
6. Network Hospital Co-Payment	Yes/No	-	-	% of co-payment opted	-

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

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

#Section 5. Emergency Air Ambulance can be opted only where Section 1.A. Accidental Hospitalization Cover and/or Section 1.B. Accidental & Illness Hospitalization Cover Sum Insured exceeds INR 3 Lakhs.

Note:

A. You can choose either one of the below covers or both the covers:

- Section 1.A. Accidental Hospitalization Cover
- Section 1.B. Accidental & Illness Hospitalization Cover

1. If You are opting only for Section 1.A, then coverage is only for Accidental Hospitalization.

2. If You are only for Section 1.B, then coverage is for both Illness and Accidental hospitalization.

Example:

If You are opting for both Section 1.A and 1.B and assuming Sum insured for Section 1.A is 1 Lakh and Section 1.B is 4 Lakhs, You are eligible for Maximum Single Claim of 5 lakhs for Accidental Hospitalisation and Maximum Single Claim of 4 lakhs for Hospitalisation due to Illness, however aggregate Sum Insured will be limited to 5 Lakhs for the Policy Period.

B. Optional Cover – “Unused Sum Insured Benefit” can only be opted if Cumulative Bonus or Cumulative Bonus Protection Cover is not opted.

Section 5. Emergency Air Ambulance can be opted only where Section 1.A. Accidental Hospitalization Cover and/or Section 1.B. Accidental & Illness Hospitalization Cover Sum Insured exceeds INR 3 Lakhs.

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, Mumbai including (Navi Mumbai, Thane and Kalyan).

Zone B: Hyderabad and Secunderabad, Bangalore, Kolkata, Ahmedabad, Vadodara, Chennai, Pune and Surat.

Zone C: Rest of India apart from Zone A and Zone B cities are classified as Zone C.

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

Note:

1. 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.
2. 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-pay would be applicable on admissible claim amount.
3. 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.
4. Zone based Co-pay, as mentioned above will not be applicable in case of Accidental Injury.

Geographical Limits:

Geographical Limits Options	<input type="checkbox"/> Within India <input type="checkbox"/> Asia <input type="checkbox"/> Worldwide Including USA & Canada <input type="checkbox"/> Worldwide Excluding USA & Canada
Options for Co-Payment where Geographical Limit is Outside India	<input type="checkbox"/> 0 % <input type="checkbox"/> 5 % <input type="checkbox"/> 10 % <input type="checkbox"/> 15 % <input type="checkbox"/> 20 %

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