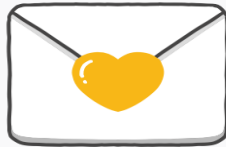


Digit Life Healthy Glow Policy

(Health Plus Life Combi Product from Go Digit General Insurance Ltd and Go Digit Life Insurance Ltd)

Proposal Form

UIN: GODHLIP26044V022526



Hi <Company name>, *Life and Health are the Biggest Treasure, you've made a wise decision to protect it!*

Your Proposal Number is XXXXXXXXX

Proposal Date	<Date>
---------------	--------

Cover Letter

Date: XX.XX.XXXX

To,
<Proposer's Name >
<Address>
<Contact Number>

Dear Sir/Madam,

We are glad that you have chosen our product '**Digit Life Healthy Glow Policy (UIN: GODHLIP26044V022526)**' and given us an opportunity to structure a product that fits into your needs.

Here is Your **Digit Life Healthy Glow Policy Proposal with Proposal No. <Proposal No.>**

Go Digit General Insurance Limited [GDGIL] and **Go Digit Life Insurance Limited [GDLIL]** jointly offering you coverage under **Digit Life Healthy Glow Policy** where, liability to settle the claim vests with respective insurers, i.e. for health insurance benefits " **GDGIL** and for life insurance benefits **GDLIL**". Any legal/quasi legal disputes would be dealt by the respective insurer.

Under **Digit Life Healthy Glow Policy**, You will Purchase two Policies I. **Digit Health Insurance Policy** offered by **Go Digit General Insurance Limited** & II. **Digit Glow Term Life Insurance** offered by **Go Digit Life Insurance Limited** as part of this combo solution.

Here is premium payment detail for Your **Digit Life Healthy Glow Policy**:

Mode of Payment	Cheque No/NEFT Ref N	Bank Name	Date	Amount (Including applicable taxes)	
				Part I (Health Insurance Section)	Part II (Life Insurance Section)

If You wish to connect with our support team for any query:

Contact Our Customer Support team:

For Health: 1800-258-4242 or mail us at hello@godigit.com

For Life: 9960126126/18002962626 or mail us at life@godigit.com

Yours Sincerely,

<Name>

<Designation>

Go Digit General Insurance Limited

I. DIGIT HEALTH INSURANCE POLICY

- 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 agree not to receive 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@godigit.com along with the Proposal Form, if applicable.

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
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			<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	2L/3L/4L/5L/7.5L/9L/ 10L/12.5L/15L/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*>
3	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*>

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																						
12	Daily Cash for accompanying an insured child	Yes/No	INR ____ Per Day & Up to ____ Days																							
13	Loss of Income Cover	Yes/No	INR ____ Per Day & Block of Days ____	Maximum number of times payable ____																						
14	Long Hospitalization Cash Benefit Cover	Yes/No	INR ____ & Minimum ____ Days Hospitalization																							
15	Out-Patient Benefit Cover	Yes/No	INR _____																							
16	Second Medical Opinion	Yes/No																								
17	Smart Save	Yes/No	<p style="text-align: center;">Capping of SI:</p> <table border="1" style="width: 100%;"> <thead> <tr> <th>Ailments</th> <th>SI Limit</th> </tr> </thead> <tbody> <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> </tbody> </table>	Ailments	SI Limit	Eye Diseases / Cataract		Knee Replacement - per knee		Angiography		Angioplasty		All types of Hernia		CABG		Hysterectomy		Kidney / Bladder Stone		Oral Chemotherapy		Hip replacement		
Ailments	SI Limit																									
Eye Diseases / Cataract																										
Knee Replacement - per knee																										
Angiography																										
Angioplasty																										
All types of Hernia																										
CABG																										
Hysterectomy																										
Kidney / Bladder Stone																										
Oral Chemotherapy																										
Hip replacement																										
18	Fast track	Yes/No		Disease/ illness/ condition covered: 1.Asthma 2.Chronic Obsutrective Pulmonary Disease (COPD) 3.Diabetes 4.Hypertension 5.Hyperlipidemia 6.Obesity 7.Coronary Artery Disease (PTCA done prior to 1 year) 8.Thyroid																						
19	Cumulative Bonus Protection Cover	Yes/No	INR ____ cumulative bonus protection cover amount	% of Cumulative Bonus as per base cover																						
20	Infinite Cumulative Bonus	Yes/No	__ With/ __ Without claims protection	If With ____ Claim amount protection																						
21	Room Rent Modification Cover	Yes/No	__ No Restriction/ __ All rooms except suite/ __ Single Private AC room/ __ Shared Accommodation/ __ Shared Accommodation max up to 5000/ __ 1% of SI*/ __ General Ward																							
22		Yes/No	__ Discount on the premium/ __ 4X of base sum insured of section 1 for named illnesses	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																						

	NRI Benefit			<ul style="list-style-type: none"> • End Stage Liver Failure • Kidney Failure Requiring Regular Dialysis • Major Organ/ Bone Marrow Transplant • Benign Brain Tumour • Coma of Specified Severity • 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

2,500 <input type="checkbox"/>	5,000 <input type="checkbox"/>	7,500 <input type="checkbox"/>	10,000 <input type="checkbox"/>	15,000 <input type="checkbox"/>
20,000 <input type="checkbox"/>	25,000 <input type="checkbox"/>	30,000 <input type="checkbox"/>	40,000 <input type="checkbox"/>	50,000 <input type="checkbox"/>

Do You have or had any retail Policy with Go Digit: Yes/No

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

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.

PREMIUM PAYMENT ZONE AND 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	2	3	4	5	Up to 1	2	3	4	> 4
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				

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)	Percentage of claim amount	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

Kindly refer Annexure 1 for detailed declaration.

Date:

Signature of the Proposer

Place:

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 L66010PN2016PLC167410, Reg. Address Atlantis, 95, 4th B Cross Road, Koramangala Industrial Layout, 5th Block, Bengaluru 560095. Website: www.godigit.com

CUSTOMER IDENTIFICATION PROCEDEURE (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 sub-mission document)
 6. Statement of saving bank account with details of present/ present address (updated up to 1 month prior to claim submission document)

II. DIGIT GLOW TERM LIFE INSURANCE

(A Non- Linked Non-Participating Individual Pure Risk Premium Life Insurance Plan)

Proposal Number:

Proposal date of filling:

For office use only
Intermediary code
Intermediary Name
POS/Specified Person's Name/Representative's Name
POS/Specified Person's Code/ Representative's Code
License Number

Please fill the below with full honesty as these details are the basis on which we will eventually be issuing the Digit Glow Term Life Insurance policy and basis which the claim can be considered in the future. So, every detail is important. Also make sure you carefully read the sales literature, given by the advisor, company or salesperson, before you start filling the form. You can contact us at life@godigit.com for any query. You can also visit our website www.godigit.com/life to learn more about us or the plan.

For any help, call Us on 9960126126/18002962626 or write to Us at life@godigit.com

Hi there/<Name>, this is amazing! You are choosing to protect life! You are choosing a term insurance policy. And thank you for considering Digit Glow Term Life Insurance for this :)

This is a proposal form which is basically us trying to understand you a little better from the point of view of being able to take a decision on whether we will be able to write the risk (your life) or not. And hoping all is good, this will help us keep your details & declarations in place for the future in case of a claim. So please be super-duper honest and transparent with us as these details will be validated later at the time of claim as well :)

Hope you understand.

The form should take about 10-20 minutes to fill in case you have all relevant details & documents handy (listed below as a quick pre-filling checklist for you to keep, in order of importance):

1. Identity proof
2. Address proof
3. Age proof
4. PAN or Form 60
5. Nominee details
6. Medical history of Life to be Insured and their immediate family members
7. Other health & life insurance policy details (existing or simultaneously applied)
8. For housewives & students, details of any life insurance policy other members of the family may hold
9. ABHA ID, if you have one
10. Electronic Insurance Account details, if you have one

Okay let us start with some basics

Before we begin, let us know if we already serve you :)

Yes, I am an existing customer of Digit

If yes, we would love to know the below details about your association with Digit:

Policy Number: _____

Registered Contact Number: _____

Any other Details: _____

Proposer/Life to be Insured details

Firstly, whose life are you covering under this policy i.e. who is the Life to be Insured?

My life/Someone else's

If Life to be Insured is not same as you, the Proposer, what is their relation to you? They are my...

Father/Mother/Brother/Sister/Spouse/
Grandfather/Grandmother/Son/Daughter/partner in a partnership firm/
employee/company-director/Trustee/Other

Note: If you are covering someone else's life, then you become the Proposer & they become the Life to be Insured. We are telling you this since we will ask you details of the Proposer and Life to be Insured separately. If you are the Proposer as well as the Life to be Insured, just fill your details for both types of question.

Recent Passport Size
Recent Photograph
of Proposer

Recent Passport
Size Recent
Photograph of Life
Insured

Note: ONLY one (1) photo is enough if you are the Proposer as well as the Life to be Insured. You can keep the other one blank.

What category do you fall under as a Proposer? <i>(Tick box if applicable)</i>	Individual / Proprietorship / Employer / Pvt or Public Ltd Company / Trust / HUF/Partnership Firm / NGO / Society / Others (please specify) _____
---	---

This policy is to insure a Keyman

Keyman refers to a key employee or executive for whom the business or organization is taking the insurance.

Details of Life to be Insured

Note: Fill the below for Life to be Insured.

KYC Documents

CKYC (if available)	
PAN (If not, please attach Form 60)	
Type of Identity Proof submitted	
Type of Permanent Address Proof submitted	
Type of Current Address Proof Submitted (If it is different than Permanent Address)	
Type of Education Proof Submitted (Optional)	

Personal details

Full name	
Father's Name / Spouse Name / Mother's Name	
Gender	Male/Female/Transgender
Date of Birth OR Age	DD/MMM/YYYY OR ___ Years
Marital Status	Single/Married/Divorced/Widowed/Others (please specify) _____
Nationality	
Country of Residence (If country of residence is outside India and for Non Indian Residents, FATCA/ CRS-Self Certification Form to be mandatorily completed)	

Contact details	
Contact number (with Country Code)	
WhatsApp Number	
E-mail ID	
Permanent Address	
Pin code of Permanent Address	
Current Address	
Pin code of Current Address	
Education and Work Details	
Education	Graduate and Above, 12th Pass/Diploma, 10th Pass and Above/Below 10th Pass
Occupation	Salaried/Professional/Self-Employed/Student/Housewife/Retired/Agriculture/Unemployed/Landlord/Others (please specify)_____
Name of Employer / Business / School / College	
Organization Type	Govt/Pvt Ltd/Public Ltd/Proprietor/Partnership/HUF/Trust/Society/NGO/NPO/Others (please specify)_____
Nature of Work	<Armed Forces/Police> <Mining> <Blue-collar Jobs> <Desk-Job/White-Collar Jobs> <Aviation> <Others, specify _____>
Annual Income (In Rs.)	
Details of the Vehicles owned	
<input type="checkbox"/> 2 Wheeler Registration no _____ <input type="checkbox"/> 2 Wheeler Registration no _____ <input type="checkbox"/> 4 Wheeler Registration no _____ <input type="checkbox"/> 4 Wheeler Registration no _____	
Additional Details (Tick box the statements that apply to you)	
<input type="checkbox"/> The proposer is a Non-Profit Organization* /Trust /Society/NGO Please share the Niti Ayog Darpan Portal Registration Number (if available) _____	
<input type="checkbox"/> You are a Politically Exposed Person (PEP)** or related to one Please provide Details (if applicable): _____	
Health & Lifestyle details (Tick box the statements that apply to you)	
Height (in Feet & Inches)	
Weight (in KG)	
Cigarettes/bidis consumption habits Tick box the statement that best applies to you:	
<input type="checkbox"/> I do not consume cigarettes/bidis <input type="checkbox"/> I regularly consume cigarettes/bidis <input type="checkbox"/> I occasionally or socially consume cigarettes/bidis	
Tobacco consumption habits Tick box the statement that best applies to you:	
<input type="checkbox"/> I do not consume tobacco <input type="checkbox"/> I regularly consume tobacco <input type="checkbox"/> I occasionally or socially consume tobacco	
Alcohol consumption habits Tick box the statement that best applies to you:	

<input type="checkbox"/> I do not consume alcohol <input type="checkbox"/> I regularly consume alcohol <input type="checkbox"/> I occasionally or socially consume alcohol																															
Additional Medical Information (Tick box the statements that apply to you)																															
Do you have any diseases or medical condition from which you have previously recovered, are presently receiving treatment/evaluation for, or are planning treatment/surgery for, currently in the near future? <input type="checkbox"/> Yes <input type="checkbox"/> No																															
Are you currently taking any medication? Or been prescribed medication or treatment for more than 7 consecutive days within the last 4 years, excluding those for conditions disclosed in the previous question or for common cold/flu? <input type="checkbox"/> Yes <input type="checkbox"/> No																															
Have you been hospitalized for any reason in the past? <input type="checkbox"/> Yes <input type="checkbox"/> No																															
Do you have any congenital/genetic disorders, and/or physical impairments, deformities, or disabilities? <input type="checkbox"/> Yes <input type="checkbox"/> No																															
If answers to any of the above questions is yes, please share details _____																															
Have you undergone medical tests in the last 4 years, such as blood tests, X-Ray, ECG, TMT, USG, Mammogram, MRI/CT scan, PET etc. other than for a routine checkup? <input type="checkbox"/> Yes <input type="checkbox"/> No <small>Note: This does NOT include routine health checkups that you may have taken before joining a new company or proactively as a part of an annual health checkup package in your health insurance by your employer or personal or to procure Life/Health insurance Policy</small>																															
If yes, please give details _____																															
ONLY in case Life to be Insured is a FEMALE (Tick box the statements that apply to you)																															
<input type="checkbox"/> I am pregnant If yes, please mention the number of weeks _____																															
<input type="checkbox"/> I have had gynecological problems or illness related to uterus/ovaries or breasts or cervix, currently or in the past.																															
If yes, please give details _____																															
Family Medical history (Tick box the statement ONLY if it applies to you)																															
<input type="checkbox"/> If an immediate family member i.e. a parent or sibling had been diagnosed or unfortunately expired , due to cancer, heart disease, stroke, or any other hereditary/familial disorders prior to the age of 60. Please share below details (if applicable)																															
<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr style="background-color: #e0e0e0;"> <th style="width: 20%;">Relation</th> <th style="width: 20%;">Alive or Expired (tick one of the below)</th> <th style="width: 10%;">Current Age/Age at Death</th> <th style="width: 20%;">If alive, disease or illness diagnosed</th> <th style="width: 30%;">If expired, cause of death</th> </tr> </thead> <tbody> <tr> <td>Father</td> <td><input type="checkbox"/> Alive <input type="checkbox"/> Expired</td> <td></td> <td></td> <td></td> </tr> <tr> <td>Mother</td> <td><input type="checkbox"/> Alive <input type="checkbox"/> Expired</td> <td></td> <td></td> <td></td> </tr> <tr> <td>Sister</td> <td><input type="checkbox"/> Alive <input type="checkbox"/> Expired</td> <td></td> <td></td> <td></td> </tr> <tr> <td>Brother</td> <td><input type="checkbox"/> Alive <input type="checkbox"/> Expired</td> <td></td> <td></td> <td></td> </tr> <tr> <td>Others (please specify) _____</td> <td><input type="checkbox"/> Alive <input type="checkbox"/> Expired</td> <td></td> <td></td> <td></td> </tr> </tbody> </table>	Relation	Alive or Expired (tick one of the below)	Current Age/Age at Death	If alive, disease or illness diagnosed	If expired, cause of death	Father	<input type="checkbox"/> Alive <input type="checkbox"/> Expired				Mother	<input type="checkbox"/> Alive <input type="checkbox"/> Expired				Sister	<input type="checkbox"/> Alive <input type="checkbox"/> Expired				Brother	<input type="checkbox"/> Alive <input type="checkbox"/> Expired				Others (please specify) _____	<input type="checkbox"/> Alive <input type="checkbox"/> Expired				
Relation	Alive or Expired (tick one of the below)	Current Age/Age at Death	If alive, disease or illness diagnosed	If expired, cause of death																											
Father	<input type="checkbox"/> Alive <input type="checkbox"/> Expired																														
Mother	<input type="checkbox"/> Alive <input type="checkbox"/> Expired																														
Sister	<input type="checkbox"/> Alive <input type="checkbox"/> Expired																														
Brother	<input type="checkbox"/> Alive <input type="checkbox"/> Expired																														
Others (please specify) _____	<input type="checkbox"/> Alive <input type="checkbox"/> Expired																														
Travel/Residential Plans (Tick box & fill if applicable)																															
<input type="checkbox"/> You travel/intend to travel outside India for a period of more than 180 days in a year																															
Name of Country																															
Name of City																															
Duration of stay																															
Nominee details <small>In case Proposer & Life Assured is different, you can SKIP the below as the nominee will be by default the Proposer. Nominee is the person to whom the claim money goes in case of Life to be Insured's unfortunate demise</small>																															

Details	Nominee 1	Nominee 2	Nominee 3	Nominee 4
Full Name				
Date of Birth				
Gender				
Relationship with Nominee				
Share of claim to be given to them (%) Note: If only one nominee, by default this % will be 100%				
Contact Number				
Email				

Appointee Details (Where the nominee is a minor)

Details	Appointee 1	Appointee 2	Appointee 3	Appointee 4
Full Name				
Date of Birth				
Gender				
Relationship with Nominee				

Additional information (Tick box the statements that apply to you)

You have an Ayushman Bharat Health Account (ABHA) registered under the Ayushman Bharat Digital Mission Yojana.

Your ABHA number (if applicable) _____

You do not have an ABHA number but want to create one.

Insurance policy details (Tick box the statements that apply to you)

You have bought any other health/life/critical illness/accident insurance policy with us or any other insurer in the past.

You had applied for any such policy but unfortunately it got declined, refused, withdrawn, postponed, or offered with restricted benefits or an increased premium.

You have made any claims against any such policies in the past.

If yes to any of the above, please share below details: _____

Name of the Insurer	
Policy Start/Proposal Date	
Decision	
Reason for above decision, if known	
Any claims made	

Additional Insurance Details of Family Members (ONLY if Life to be Insured is a Housewife or Student)

Relation	Age	Insurer	Sum Assured
For Students			
Father			
Mother			
Brother			
Sister			
For Housewives			
Spouse			

Proposer details

If the Proposer is not the Life to be Insured, additionally share the below details as well

If Proposer and Life Assured are the same, you can SKIP the below.

KYC Documents

CKYC (if available)	
PAN (If not, please attach Form 60)	

Type of Identity Proof submitted	
Type of Permanent Address Proof submitted	
Type of Current Address Proof Submitted (If it is different than Permanent Address)	
Type of Education Proof Submitted (Optional)	
Personal details	
Full name	
Father's Name / Spouse Name / Mother's Name	
Gender	Male/Female/Transgender
Date of Birth	
Age	
Marital Status	Single/Married/Divorced/Widowed/Others (please specify)_____
Nationality	
Country of Residence (If country of residence is outside India and for Non Indian Residents, FATCA/ CRS-Self Certification Form to be mandatorily completed)	
Contact details	
Contact number	
WhatsApp Number	
E-mail ID	
Permanent Address	
Pin code of Permanent Address	
Current Address	<input type="checkbox"/> Same as Permanent Address or Current Address
Pin code of Current Address	<input type="checkbox"/> Same as Permanent Address
Education details and Work Details	
Education	Graduate and Above, 12th Pass/Diploma, 10th Pass and Above/Below 10th Pass
Occupation	Salaried/Professional/Self-Employed/Student/Housewife/Retired/Agriculture/Unemployed/Landlord/Others (please specify)_____
Name of Employer / Business / School / College	
Organization Type	Govt/Pvt Ltd/Public Ltd/Proprietor/Partnership/HUF/Trust/Society/NGO/NPO/Others (please specify)_____
Nature of Work	<Armed Forces/Police> <Mining> <Blue-collar Jobs> <Desk-Job/White-Collar Jobs> <Aviation> <Others, specify _____>
Annual Income (In Rs.)	
Details of the Vehicles owned	
<input type="checkbox"/> 2 Wheeler Registration no _____ <input type="checkbox"/> 2 Wheeler Registration no _____ <input type="checkbox"/> 4 Wheeler Registration no _____ <input type="checkbox"/> 4 Wheeler Registration no _____	
Additional details (Tick box the statements that apply to you)	
<input type="checkbox"/> The proposer is a Non Profit Organization* / Trust / Society / NGO	
Please share the Niti Ayog Darpan Portal Registration Number (if available) : _____	
<input type="checkbox"/> You are a Politically Exposed Person (PEP)** or related to one	
Please provide Details (if applicable): _____	
<input type="checkbox"/> You have been convicted/investigated for any criminal offense in the past.	
Please provide details (if applicable): _____	

You have an Ayushman Bharat Health Account (ABHA) registered under the Ayushman Bharat Digital Mission Yojana.

Your ABHA number (if applicable) _____

You do not have an ABHA number but want to create one.

Proposer's electronic account details (Select the appropriate options of your choice)

You have an E-Insurance Account (eIA)

Your eIA Number (if applicable) _____

Your eIA Service Provider (if applicable) _____

You would like to convert your policies with Go Digit LI into electronic policies.

You would like to open an E-Insurance Account (eIA) and convert your policies into electronic policies.

Preferred Service Provider: _____

You would be okay to have a soft copy of your policy document.
(Recommended option to keep Mother Earth green!)

Payment details for the policy

Account Holder's Name

Account Number

Account Type

UPI ID

IFSC Code

Method of First Deposit

Amount (Rs)

Cheque/DD Issuing Bank

Cheque/DD Number

Mode for Renewal Premium

Who is paying for the premium?

I, the Proposer
Life to be Insured
Third Party (someone else but related)

ONLY if Payor is a Third Party, please provide the below

Premium Payor's Name

Relationship to Proposer

Date of Birth

DD-MMM-YYYY

*Non-profit organization means any entity or organization, constituted for religious or charitable purposes referred to in clause (15) of section 2 of the Income-tax Act, 1961, that is registered as a trust or a society under the Societies Registration Act, 1860 or any similar State legislation or a Company registered under the section 8 of the Companies Act, 2013.

**Politically Exposed Person or PEP are individuals who are or have been entrusted with prominent public functions in India or abroad, e.g. Heads of States or Governments, Sr. Govt./judicial/military officers, Sr. Executives of State-Owned corporations, political party officials & family members of these individuals (spouse, children, parents, siblings, in-laws).

Product Details

Sum Assured on Death (Rs.)

<Amount>

Policy Term

< _____ > Year/(s)

Premium Details

Premium Payment Term

< _____ > Years

	Premium Payment Frequency	<Single> <Annual> <Half-Yearly> <Quarterly> <Monthly>
	Modal Premium in first policy year (Rs.)	<Amount>
	Modal Premium in subsequent policy years (Rs.)	<Amount> <Not Applicable>

Note:

1. Cheque/ DD should be drawn in favor of "Go Digit Life Insurance Ltd. Proposal Number - <Proposal Number>" only. Please mention proposal no. and name of the proposer behind the cheque/DD.
2. In the event of non-realization of first premium deposit, the policy, if issued, shall be treated as cancelled/void from inception.
3. In case of non-acceptance/ withdrawal of this application for insurance, the company shall return the first premium deposit without any interest and after deducting the expenses incurred on the medical tests/ examination.
4. Kindly submit PAN/Form 60 (as defined under Income Tax Rules, 1962), at the time of applying for the policy. The premium payment can be done only through the acceptable premium collection modes. Where any customer/proposer wishes or proposes to make any payment in cash, it can be accepted up to the limit of ₹49,999/- only at the authorized collection points. In case you opt to pay cash up to an acceptable limit, you are requested to pay cash only at the authorized collection points and not to advisor or employee. The company will not be responsible for any loss in this regard.
5. Please submit a cash authority letter along with the cash if you are depositing the cash through a third party.
6. Payments made through credit cards can be accepted only if the card is issued in the name of the relevant proposer/ policy holder / Life to be Insured. Payment shall be made only by person having insurable interest in the Policy.

Declaration and Authorization

Kindly refer Annexure 1 for detailed declaration.

Please sign the Proposal Form and share it with the Insurer. The Proposer and Life to be Insured, if applicable can also sign the Proposal form digitally /electronically.

Signature/Thumb impression of Proposer / Confirmed Electronically	Signature / Thumb impression of Life to be Insured / Confirmed Electronically	Date <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/>	Place <input style="width: 100%;" type="text"/>
---	---	--	---

Declaration (If proposal form is signed in vernacular language / if thumb impression is affixed above/ Proposal Form is filled by person other than Proposer or Life to be Insured)

Declaration by the person filling in the form (In case form is filled up / signed in a language different from that of the Proposal Form)

"I hereby declare that I have fully explained the above questions to the proposer and I have truthfully recorded the answers given by the proposer."

Name of the Declarant: _____

Address of the Declarant: _____

	Date: <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/>	Place: _____
--	---	--------------

"I certify that the contents of the form have been fully explained to me by (Name, Designation, and occupation) Mr. / Mrs.: _____ and I have understood the same.

Signature / Thumb Impression of Proposer / Confirmed Electronically	Date <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/>	Place <input style="width: 100%;" type="text"/>
---	--	---

In case the Proposer is illiterate, his/her thumb impression should be attested by a person of standing whose identity can easily be established, but unconnected with the insurance Company and this declaration should be made by him.

"I hereby declare that I have fully explained the above questions and contents of the proposal form to the proposer in _____ language, and that the proposer has affixed the thumb impression above after fully understanding the contents thereof."

Name of the Declarant: _____

Address of the Declarant: _____

	Date: <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/>	Place: _____
--	---	--------------

Section 39 of Insurance Act 1938

The nomination shall be applicable subject to Section 39 of the Insurance Act, 1938, as amended from time to time. This section enables policy holder to

nominate any person or persons to whom the money secured by the policy can be paid in the event of death of the person whose life is insured. If the nominee is minor, it is advisable to appoint a person who can secure money on behalf of the minor. If there is any assignment or transfer made in the policy, nomination will be deemed cancelled. Other information in this regard can be ascertained on our website and/or from the agent or the insurance intermediary prospect may like to engage.

Section 41 of the Insurance Act, 1938 (4 of 1938) as amended from time to time:

In accordance with Section 41 of the Insurance Act, 1938 as amended from time to time, 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 or continuing a policy accept any rebate, except such rebate as may be allowed in accordance with the published prospectus or tables of the insurer.

Section 45 of the Insurance Act, 1938 as amended from time to time:

1. No policy of life insurance shall be called in question on any ground whatsoever after the expiry of three years from the date of issuance of the policy or the date of commencement of risk or the date of revival of the policy or the date of the rider to the policy, whichever is later.

2. On ground of fraud, a policy of life insurance may be called in question within three years from the date of issuance of the policy or the date of commencement of risk or the date of revival of the policy or the date of the rider to the policy, whichever is later. For this the insurer shall have to communicate in writing to the insured or the legal representatives or nominees or assignees of the insured, as applicable, the grounds and materials on which such decision is based.

3. Fraud means any of the following acts committed by insured or by his agent, with the intent to deceive the insurer or to induce the insurer to issue a life insurance policy : (i) The suggestion, as a fact of that which is not true and which the insured does not believe to be true; (ii) The active concealment of a fact by the insured having knowledge or belief of the fact; (iii) Any other act fitted to deceive; and (iv) Any such act or omission as the law specifically declares to be fraudulent.

4. Mere silence is not fraud unless, depending on circumstances of the case, it is the duty of the insured or his agent keeping silence to speak or silence is in itself equivalent to speak.

5. No insurer shall repudiate a life insurance policy on the ground of fraud if the insured / claimant can prove that the mis-statement was true to the best of his knowledge and that there was no deliberate intention to suppress the fact or that such mis-statement of or suppression of a material fact are within the knowledge of the insurer. The onus of disproving lies upon the Policyholder, if alive, or claimant.

6. A life insurance policy may be called in question at any time within three years from the date of issuance of the policy or the date of commencement of risk or the date of revival of the policy or the date of the rider to the policy, whichever is later, on the ground that any statement of or suppression of a fact material to the expectancy of the life of the insured was incorrectly made in the proposal or other document on the basis of which the policy was issued or revived or rider issued. For this, the insurer shall have to communicate in writing to the insured or the legal representatives or nominees or assignees of the insured, as applicable, the grounds and materials on which such decision to repudiate the policy of life insurance is based. Provided further that in case of repudiation of the policy on the ground of misstatement or suppression of a material fact, and not on the ground of fraud, the premiums collected on the policy till the date of repudiation shall be paid to the insured or the legal representatives or nominees or assignees of the insured, as applicable, within a period of ninety days from the date of such repudiation.

7. Fact shall not be considered material unless it has a direct bearing on the risk undertaken by the insurer. The onus is on insurer to show that if the insurer had been aware of the said fact, no life insurance Policy would have been issued to the insured.

8. The insurer can call for proof of age at any time if he is entitled to do so and no Policy shall be deemed to be called in question merely because the terms of the Policy are adjusted on subsequent proof of age of life insured. So, this Section will not be applicable for questioning age or adjustment based on proof of age submitted subsequently.

Digit Glow Term Life Insurance, Go Digit Life Insurance Limited. IRDAI Registration number: 165, CIN: U66000PN2021PLC206995, Registered Office: Go Digit Life Insurance Limited, Ananta One (AR One), Pride Hotel Lane, Narveer Tanaji Wadi, City Survey No. 1579, Shivajinagar, Pune-411005; Corporate Office: Go Digit Life Insurance Limited, Atlantis,95,4th B Cross Road, Koramangala Industrial Layout, 5th Block, Bengaluru, Karnataka 560095; Helpline Number: 9960126126/18002962626; Website:www.godigit.com/life Email: life@godigit.com

HOW TO FILE A CLAIM?



9960126126/18002962626



lifeclaims@godigit.com



9960126126

ANNEXURE 1
(DECLARATION & WARRANTY ON BEHALF OF ALL PERSONS TO BE INSURED)

- I/ We understand that this 'Combi-Product' of Health insurance and Life insurance is jointly offered by "Go Digit General Insurance Limited ["GDGIL"] and Go Digit Life Insurance Limited ["GDLIL"] respectively, individually referred to as "Insurer" and collectively referred to as 'Insurers'.
- I/we understand that the risks assumed under this 'Combi Product' are distinct and are assumed / accepted by respective insurer. The Product is also independently available from the respective Insurer.
- I/ We understand that the liability to settle the claim vests with respective insurers, i.e. for health insurance benefits " GDGIL and for life insurance benefits "GDLIL". Any legal/quasi legal disputes, would be dealt by the respective insurer.
- I/ We understand that I am / We are eligible to continue with either part of this Combi-Product, discontinuing the other during the policy term.
- I/ We understand that all policy servicing requests pertaining to this Combi-Product shall be received by either of the insurers. All requests impacting premium or policy terms towards the coverage of a particular insurer shall be serviced by the respective insurer.
- I/We hereby declare, on my behalf and on behalf of all persons proposed to be insured, that the statements, answers and/ or particulars given by me/us are true and complete in all respects to the best of my knowledge and that I/We am/are authorized to propose on behalf of these other persons. I/ We understand that the information provided by me/us will form the basis of the insurance policy, is subject to the underwriting policy of the Insurers and that the policy will come into force as per the Risk commencement date subject to receipt of full premium chargeable.
- I/ We declare that I/We consent to the Insurer 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 or any other entity/individual 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/ We confirm that I am/We are advised to familiarize myself/ourselves with the policy benefits and service structure of the 'Combi Product' before deciding to purchase the policy.
- I/we have answered the questions in the proposal after fully understanding the nature of the questions and importance of disclosing all material information. I/ We understand that any false declaration or misrepresentation may be liable for rejection of the proposal form or the contract of insurance shall be treated null & void from inception.
- I/We declare that all/any amounts paid/payable towards the policy will be paid out of legally declared and assessed sources belonging to me/us/insured person and there will be no payment of premium through a third party and will be in accordance with Prevention of Money Laundering Act 2002 and any other applicable laws as amended from time to time.
- I/ We undertake to notify insurer of any change in the information given by me/ us in the proposal form and annexures, with respect to members including change in their state of health or change in occupation or any decisions about their existing policies or proposals, subsequent to the signing and submitting of this Proposal form and before the acceptance of the risk by the Company.
- I/We also hereby authorize any organization, institution or individual that has any records or knowledge of the Life to be insured's health or medical history, employment, business, income or other details as may be required or considered relevant to divulge to the Insurer and the Insurer to divulge the same to any organization, institution or individual in connection with this proposal form or the resultant Policy. Further, I/We understand that in the event of any person being physically/medically examined, the answers given to the medical examiner/examiner by any mode, shall be deemed to be duly incorporated and form the basis for issuance of the Policy.
- I/We understand that submission of proposal form along with premium is not to be construed as commencement of risk. Risk shall only commence upon acceptance of my proposal by the Insurer as mentioned in the policy. The Insurer reserves the right to accept, decline or offer alternate terms on my proposal.
- By submitting your contact number and email ID, you authorize the Companies to call, send SMS, messages over internet-based messaging application like WhatsApp and email relating to this proposal or any matter concerning the policy that may be issued pursuant to this proposal and/or offer you information and services for the product(s) you have opted for as well as other products/services offered by the Company including all service-related communications by electronic mode. Please note that such authorization will be over and above any registration of the contact number on TRAI's NDNC registry.
- The authorization includes consent required under Digital Personal Data Protection Act, 2023 features of which are explained to me/us.
- I /We authorize the Insurer(s) to receive, retain, use and share any information provided by me in and along with the proposal form, including personal/sensitive personal information, medical records, KYC, documents and any conversation with (i) Governmental and/or Regulatory Authority, (ii) Insurance Repositories (iii) UIDAI/NSDL/CERSAI (iv) Reinsurers/Group companies, (v) issuing entities (vi) other insurance companies/third parties and vendors engaged by the insurer(s) for proposal underwriting, servicing, claims settlement, internal assessment, KYC, KYC authentication, download, CKYC updation/creation and receiving/verifying my/our information including demographic information, photograph, offline verification, claim settlement and policy servicing and voluntarily give my/our consent to use the information.

Please read declaration wordings carefully before signing the proposal form.

Date:

Place:

Signature of the Proposer

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:

Go Digit General Insurance Limited, IRDAI Reg No. 158, Corporate Identification Number L66010PN2016PLC167410, Reg. Office Address Ananta One (AR One), Pride Hotel Lane, Narveer Tanaji Wadi, City Survey No. 1579, Shivajinagar, Pune-411005; Corporate Office Address- Atlantis, 95, 4th B Cross Road, Koramangala Industrial Layout, 5th Block, Bengaluru 560095. Website: www.godigit.com

Go Digit Life Insurance Limited, IRDAI Reg No. 165, Corporate Identification Number U66000PN2021PLC206995, Reg. Office Address Ananta One (AR One), Pride Hotel Lane, Narveer Tanaji Wadi, City Survey No. 1579, Shivajinagar, Pune-411005; Corporate Office Address: Atlantis, 95, 4th B Cross Road, Koramangala Industrial Layout, 5th Block, Bengaluru 560095. Website: www.godigit.com/life
