

Annexure

Aegon Life Group Protection Plan

Channel Code

Policy Number

IMPORTANT NOTES TO THE LIFE ASSURED

1. Please fill the Proposal form in **BLOCK LETTERS** and disclose all facts. Any correction or overwriting in the Proposal must bear your full signature along with the seal of the Company at the location of our General Office, or in any other manner as may be approved by the Company.
2. You are required to disclose ALL material facts and circumstances in this form, which shall form the basis of the contract, otherwise the cover shall stand void at the option of the Company. If you are in doubt as to whether any of the facts and circumstances are material or not, you must disclose them.
3. If the Life Assured / Borrower signs this proposal in vernacular or put their thumb impression upon it, then the respective declaration must be completed.
4. Answers should be legible. Questions should be answered in 'Yes' or 'No'. (Strokes / Dots / Dashes / leaving the questions unanswered will not be accepted). Details need to be provided in case of affirmative answers.
5. Aegon Life reserves the right to seek additional information for a non-employer employee group.

SECTION I : DETAILS OF LIFE ASSURED AND COVERAGE INFORMATION

1. PERSONAL INFORMATION OF THE LIFE ASSURED

1.1 *Name of Life Assured/ Employee ID	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs./Ms. <input type="text"/>
1.2 Father's Name	<input type="text"/>
1.3 *Gender	<input type="text"/>
1.4 *Date of Birth	<input type="text" value="DDMMYYYY"/>
1.5 Pan No.	<input type="text"/>
1.6 Annual Income	<input type="text"/>
1.7 Occupation	<input type="text"/>
1.8 Nature of Duties	<input type="text"/>
1.9 Contact No.	<input type="text"/>

Fields marked in * are minimum details required to issue the coverage.

DETAILS OF NOMINEE / APPOINTEE (AN APPOINTEE, IF REQUIRED, MUST BE A MAJOR)

Name of Nominee	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs./Ms. <input type="text"/>
Date of Birth of Nominee	<input type="text" value="DDMMYYYY"/>
Nominee Relationship With Life Assured	<input type="text"/>
Name of Appointee (if Nominee is minor)	<input type="text"/>
Date of Birth of Appointee (if Nominee is minor)	<input type="text" value="DDMMYYYY"/>
Relationship To Nominee (if Nominee is minor)	<input type="text"/>

SECTION II : INSURANCE COVERAGE INFORMATION

Plan/Raider Name	Variant Name	Sum Assured	Coverage Period (months)	Installment Premium (Rs.)	Goods & Service Tax (Rs.)	Total Installment Premium (Rs.)

Note: Premium Payment Term, Premium Frequency & Type of Sum Assured is as per the scheme rules, which is available with the policyholder. Rider Sum Assured shall not exceed Sum Assured of Base Plan.

SECTION III : QUESTIONS ON HEALTH DECLARATION: (TO BE FILLED IN, BASIS THE BOARD APPROVED UNDERWRITING POLICY)

Part A and/or B and/or C and/or D will be applicable as per our Board Approved Underwriting Policy:

PART A

Are you in sound health, are suffering/have not ever suffered from any illness/disease (other than minor conditions like common cold, flu etc.) and do not have any physical defect, deformity or disability and that you are able to perform all your routine activities independently? <Yes/No>

PART B

QUESTION	RESPONSE
Have you ever suffered/Are you suffering from any illness/disease (other than minor conditions like common cold, flu etc.) for which you had to seek/are currently undertaking medical advice/treatment?	<input type="checkbox"/> Yes <input type="checkbox"/> No
During the past 3 years, have you been advised or undergone any surgery (other than dental, caesarean and cosmetic surgery) or required treatment with an admission in hospital/clinic for more than 3 days in continuation or undergone any medical tests with abnormal results?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Are you taking/Have you been prescribed any regular (daily/weekly/fortnightly/monthly) medication/treatment/diagnosis for Cancer, elevated Blood pressure, elevated Blood Sugar, elevated Cholesterol, Asthma, Chest Pain, HIV/ AIDS, Heart/ Liver/ Kidney disorders, Alcoholism, or any physical or mental disability?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Height _____ cms. Weight _____ kgs. (If applicable)

PART C

Following questions will be applicable as per our Board Approved Underwriting Policy.

BLOCK 1. PERSONAL DETAILS OF LIFE TO BE INSURED

1. Habits and Personal details

QUESTION	RESPONSE
1.1 a) Do you consume alcohol? If yes, please provide details _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
1.1 b) Have you smoked cigarettes/bidis or used any other products containing tobacco/nicotine in last 1 year? If yes, please provide details _____	<input type="checkbox"/> Yes <input type="checkbox"/> No

1.2 Do you engage or intend to engage in any aerial flight other than a fare-paying passenger on a commercial airline, sports, races, business or occupation or any hobby of a hazardous nature?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
1.3 Has any of your applications for reinstatement for life, health or accident insurance with Aegon Life Insurance company, or any other insurance company, ever been declined, deferred, withdrawn or accepted at extra premium or reduced cover?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
1.4 Has the life to be insured remained absent from his/her place of work for more than 7 days, on health grounds or claimed against his/her health insurance policies?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

BLOCK 2. FAMILY HISTORY

Did more than one of your biological parents or siblings suffer from any medical condition before they were 60 years? (E.g. diabetes, high blood pressure, Angina, heart attack, any heart disorder, polycystic kidney disease, cancer, etc.)

Yes No

If yes, please give details

BLOCK 3. RESIDENTIAL AND FOREIGN TRAVEL

3.1 Residential Status:

Resident Indian NRI/PIO/OCI

If NRI/PIO/OCI please provide the city and country of residence, _____

3.2 Do you have any plans to Travel abroad? Yes No

BLOCK 4. MEDICAL HISTORY OF THE LIFE TO BE INSURED

4.1 Height _____ cms. Weight _____ kgs. (If applicable)

4.2. Have you ever been diagnosed, tested, consulted a doctor, hospitalized, treated or experienced any of the below conditions?

TYPE OF DISORDERS/RELATED TO	DETAILS	LIFE TO BE ASSURED
a) Blood Pressure/cholesterol/ Heart Disease	High blood pressure/ Hypertension, High cholesterol/Lipids, Heart attack /Chest pain, Heart disease , Heart murmur , Palpitation, Rheumatic fever, any other disease or abnormality of heart, Pulse or Arteries, Coronary Bypass, Valve replacement, Angioplasty.	<input type="checkbox"/> Yes <input type="checkbox"/> No
b) Cancer/ Tumors /Enlarged Lymph Node / Cyst	Cancer, Tumor, Abnormal Growths, Cyst, enlarged Lymph nodes, Leukemia, Lymphoma, Polyp or undergone chemotherapy or radiotherapy, Thyroid Disorder/Goiter, Pituitary Tumors or other hormonal disorders.	<input type="checkbox"/> Yes <input type="checkbox"/> No
c) Kidneys/Bladder/ Prostate/ Liver/Reproductive organs disorder	Disease of Kidney, Bladder, Urinary system, Reproductive organs, Enlargement of Prostate, Renal Calculi/Stone, Gastrointestinal or liver disorders, like Ulcer ,Colitis, Chronic Diarrhea, Piles, Fistula, Jaundice/Hepatitis, Hernia , Cirrhosis, Recurrent indigestion, Other disease of liver, stomach & bowels.	<input type="checkbox"/> Yes <input type="checkbox"/> No
d) Diabetes /Elevated Blood Sugar	Diabetes/ Raised blood sugar/ Sugar in urine.	<input type="checkbox"/> Yes <input type="checkbox"/> No
e) Respiratory or Lung disorders	Respiratory disorders like Asthma, Tuberculosis/Shortness of breath/Chronic cough/ Chronic Bronchitis, Emphysema, Pneumonia, Other Chest & lung complaints.	<input type="checkbox"/> Yes <input type="checkbox"/> No
f) Bone & Spine Disorder /Physical Deformity/Defects.	Rheumatic Arthritis, Polio, Gout, Slip Disc, Osteopenia, Osteomyelitis or any disease of the joints, bones, spine or muscles, Physical deformity/defect, Congenital & Genetic disease.	<input type="checkbox"/> Yes <input type="checkbox"/> No
g) Nervous or Psychiatric Disorder	Nervous system disorders/ailments related to Brain , Stroke, Transient ischemic attack, Epilepsy, Paralysis, Fits/ Seizures, Coma, Head injury, dizzy or fainting spells, Multiple sclerosis, Any mental illness including Psychiatric Disorder, Schizophrenia, Depression, Anxiety, Stress, Nervous Breakdown or Insomnia	<input type="checkbox"/> Yes <input type="checkbox"/> No

h) ENT	Any disease or disorder of ear, nose, eyes or throat, including defective sight or hearing and discharge from ears?	<input type="checkbox"/> Yes <input type="checkbox"/> No
i) During last three years, has the life to be insured consulted a Medical Practitioner for any ailment /injury requiring treatment for more than 7 days?		<input type="checkbox"/> Yes <input type="checkbox"/> No
j) During last three years, has the life to be insured undergone any cardiological / pathological or radiological tests, other than routine testing for insurance or employment?		<input type="checkbox"/> Yes <input type="checkbox"/> No
k) HIV/AIDS/Hepatitis B or C/Sexually Transmitted Diseases (applicable to you and your spouse)		<input type="checkbox"/> Yes <input type="checkbox"/> No
l) Any Other Illness/Disorder / Symptom not mentioned above : _____		

BLOCK 5. FOR FEMALE LIVES TO BE INSURED ONLY

a) Is the life to be insured pregnant now?	<input type="checkbox"/> Yes <input type="checkbox"/> No
b) Has the life to be insured had any abortion or miscarriage or caesarian section	<input type="checkbox"/> Yes <input type="checkbox"/> No
If the answer to a) or b) above is "YES" then please give details : _____	

PART D

Applicable only if COVID-19 benefit(s) is/are opted

I DECLARE THAT	RESPONSE
1 I have not travelled outside of India in the last 45 days from the date of this proposal	<input type="checkbox"/> Yes <input type="checkbox"/> No
2 I have not been quarantined or been in close contact with anyone who has been diagnosed positive for COVID-19 in the last 14 days from the date of this proposal and	<input type="checkbox"/> Yes <input type="checkbox"/> No
3 I have not experienced any of the following symptoms within the last 14 days from the date of this proposal <ul style="list-style-type: none"> ● Any fever/Cough/Shortness of breath/Malaise (flu-like tiredness)/Rhinorrhea (mucus discharge from the nose)/Sore throat/Gastro-intestinal symptoms such as nausea, vomiting and/or diarrhea 	<input type="checkbox"/> Yes <input type="checkbox"/> No

DECLARATION:

I declare that I have never suffered from or been treated for any form of symptoms of

- Cancer / tumor
- Heart disease or heart attack
- Stroke
- Diabetes / increased blood sugar
- Increased Cholesterol diagnosed by a doctor, hospital or clinic as being raised above normal limits
- Increased Blood pressure diagnosed by a doctor, hospital or clinic as being raised above normal limits
- Chest and/or heart surgery, or have been advised medically to undergo chest and/or heart surgery in the future
- Kidney disease
- Liver disease including hepatitis
- Kidney and / or liver failure
- Paralysis or paraplegia

- Major organ transplantation, or have not been advised to undergo a major organ transplantation (such as for example heart, lung, liver or kidney etc) in the future
- Any neurological or nervous disorder
- HIV infections, AIDS or venereal diseases
- Disorder of the bones, spine or muscle

SECTION IV : DECLARATION AND CONFIRMATION BY THE LIFE TO BE ASSURED, IN CASE NON-EMPLOYER-EMPLOYEE GROUPS

I confirm that the answers I have given are, to the best of my knowledge, true, and that I have not withheld any material information that may influence the assessment or acceptance of this application.

I agree that I will inform the Company if between the date of this proposal and the date of the issuance of the policy there is any change in my general health, occupation, or financial position.

I/We understand that any mis-statement or suppression or non-disclosure of material information submitted or where the Company is not notified of any change as mentioned above, the Company reserves the right to repudiate the claim or declare the policy void in accordance with Section 45 of the Insurance Act.

I agree that the Insurance protection shall only be provided effective from the date of acceptance of risk by the Company.

I declare that the statements in this proposal are true and I have disclosed all information which might be material to the Company while issuing the policy contract.

I declare that the premiums paid have not been generated from the proceeds of any criminal activities/offences and I shall abide by and conform to the Prevention of Money Laundering Act 2002 or any other applicable laws.

I declare that the Company has disclosed and explained all the information related to this product and riders to me and I declare that I have understood the same before signing this proposal form.

I hereby agree and authorize the Company that my contact details or other information may be shared on confidential basis, with any service provider/third party agency with whom the Company has tie- ups/arrangements for processing of this proposal or servicing of the resulting policy

I hereby confirm that I have voluntarily provided my Contact details, including my telephone number and Email address to the Company and I hereby consent to receiving information related to this proposal and resulting policy, through SMS/Email as updated by me from time to time

I understand that The Company reserves the right to accept, decline or offer alternate terms on this application for life insurance.

Name of the Declarant: _____

Signature: _____

Date: _____

Address of the Declarant:

SECTION 5: DECLARATION TO BE SUBMITTED FOR LOAN AUTHORIZATION, IN CASE OF LENDER BEING A REGULATED ENTITY

For lender - borrower insurance policy, I hereby authorize the Company to make the payment of outstanding loan balance amount to the Master Policyholder by deducting from the claim proceeds payable on the happening of the contingent event covered under the scheme/policy.

Name of the Declarant: _____

Signature: _____

Date: _____

Address of the Declarant:

Declaration to be submitted if the form is signed in vernacular or bears the thumb impression of the Proposer / Life to be Assured:

1. 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: _____

Signature: _____

Date: _____

Address of the Declarant:

"I certify that the contents of the form and documents have been fully explained to me by (Name, Designation, occupation)

Mr. / Mrs.: _____ and I have understood the significance of the proposed contract.

Signature or thumb impression of the person whose life is proposed to be assured

2. 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 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: _____

Signature: _____ Date: _____

Address of the Declarant:

In addition, the below declarations will be applicable for health products/riders:

1. I hereby declare that the above statements, answers and/or particulars given by me are true and complete in all respects to the best of my knowledge
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 Company and that the policy will come into force only after full payment of the applicable premium .
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 and consent that 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.

Name of the Declarant: _____

Signature: _____

Date: _____

Address of the Declarant:

Extract of Section 41 of 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 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. Any person making default in complying with the provisions of this section shall be liable for a penalty which may extend to ten lakh rupees."

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

Fraud, Misrepresentation and forfeiture would be dealt with in accordance with provisions of Section 45 of the insurance Act 1938 as amended from time to time. Some provisions of the Section have been reproduced for reference:

- 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 the policy, i.e, 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 rider to the policy, whichever is later
- 2) A policy of life insurance may be called in question at any time within three years from the date of issuance of 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 of fraud Provided that the insurer shall have to communicate in written to the insured or the legal representative or nominees or assignees of the insured the grounds and materials on which such decision is based.
- 3) Notwithstanding anything contained in sub-section (2) no insurer shall repudiate a life insurance policy on the ground of fraud if the insured can prove that the mis-statement of or suppression of a material fact was true to the best of his knowledge and belief or 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. Provided that in case of fraud the onus of the disproving lies upon the beneficiaries, in case the policyholder is not alive.
- 4) A policy of life insurance may be called in question at any time within three years from the date of issuance of the policy or the date of revival of the policy or the date of the rider to the policy, whichever is late, 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: Provided that the insurer shall have to communicate in writing to the insured or the legal representatives or nominees or assignees of the insured the grounds and materials on which such decision to repudiate the policy of the 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 within a period of ninety days from the date of such repudiation.
- 5) Nothing in this section shall prevent the insurer from calling 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 that the age of the life insured was incorrectly stated in the proposal.

"Free look Clause"

If you are not satisfied with any of the terms and conditions of the Policy, you may return the policy document or certificate of insurance along with a letter stating the reason for disagreement within 15 days or 30 days(if purchased through Distance Marketing mode¹) of receipt of the policy document or certificate of insurance. ¹Distance marketing: Distance marketing includes every activity of solicitation (including lead generation) and sale of insurance products through the following modes: (i) Voice mode, which includes telephone-calling (ii) Short Messaging service (SMS) (iii) Electronic mode which includes e-mail, internet and interactive television(DTH) (iv)Physical mode which includes direct postal mail and newspaper & magazine inserts and (v) Solicitation through any means of communication other than in person.