



Inward Number _____
Proposal Number _____
Date of receipt of Proposal _____
Policy Number _____
Date of policy issuance: _____

Plan Name. LIC's Cancer Cover Plan
Plan No. _____
Pol. Term /PPT _____
Premium Mode _____
Installment Premium _____

Latest Photograph

URN: HPF-1

PROPOSAL FORM FOR LIC'S CANCER COVER

Branch Office..... Divisional Office..... R/U/F/S.....
 Agent's Name Code No..... Authorisation No..... Authorisation expiry date.....
 Development Officer's name..... Development Officer's Code.....

1. PROPOSER DETAILS:

Full Name (Max 40 Char)							
Father's Name							
Nationality			If NRI, Country of Residence				
Place of Birth			Objective of Insurance				
Age Proof (Nature of Age Proof)		Date of Birth	Age (Lbd)	Sex	Male/Female		
Address for communication							
City/Town							
State							
Permanent residential Address							
City/Town							
State							
Telephone		STD code Phone No.....		Mobile	(+91)		
E-Mail id							
Residence Proof							
Qualification			Annual Income & Source of Income		Rs.		
Occupation			Income Proof				
Name of Employer			Nature of Duty				
PAN Number-		Aadhar No.-		Passport No.-			
Are you (Proposer) registered under the GST Act: Yes / No If Yes, Provide GSTIN _____.							
Term		Mode of Premium Payment	Sum Assured	Benefit Options (Choose one of the following options)			
				Option I- Level Sum Insured: <input type="checkbox"/>	Option II- Increasing Sum Insured: <input type="checkbox"/>		

2. PROPOSAL DEPOSIT DETAILS: Cash Cheque

BOC No.		Date		Amount Rs.	
ONLINE proposal (access ID)					

3. NOMINATION DETAILS:

Nominee's Full Name			
Age		Relationship	
Appointee's Name (if Nominee is minor)		Appointee's Signature	
Appointee's address			

4. **BANK DETAILS:** (Please enclose a cancelled cheque)

IFSC (11 digits)		MICR Number (As given on the cheque leaf)	
Account Number (As given on the cheque leaf)		Account Type (Savings/Current)	
Bank Name		Bank Branch	

5. Has any of your new proposal/ application for revival/reinstatement for medical, health related insurance or riders or critical illness been refused, withdrawn, declined, postponed or offered with restricted benefits or with an increased (extra) premium with LIC or any other insurer in India or abroad?

If Yes, please provide details in the table below

YES| NO

Name of the Insurer	Policy No	Plan/ CI Rider & Term	Sum Assured	Date of commencement	Terms of Acceptance/Decline/Postpone/Reject	Reason for substandard Terms/Decline/Postpone/Reject

6. Are you a politically exposed person OR are you a family member or close relative of politically exposed person? [As per RBI guidelines PEPs are the individuals who are or have been entrusted with prominent public functions in a foreign country] { Yes / No }

7. **HEALTH DETAILS AND MEDICAL INFORMATION**

DETAILS	Remarks																					
i. Do you consume or have ever consumed Narcotics?	<input type="checkbox"/> Yes <input type="checkbox"/> No																					
ii. Do you smoke cigarettes/ bidis or consume tobacco in any form? a) If yes, please specify the number of cigarettes/ bidis smoked per day _____ b) Have you consumed any form of chewable tobacco in the last 12 months?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No																					
iii. Have you ever been advised to quit alcohol consumption for health reasons OR diagnosed with any liver abnormalities due to alcohol consumption?	<input type="checkbox"/> Yes <input type="checkbox"/> No																					
iv. Has either of your parents and /or brother or sister suffered/suffering from, or died due to cancer before the age of 60 years? If YES give following details; What type of Cancer _____ Relation with the person contracting Cancer _____ Age at diagnosis _____ Age at Death (if any) _____	<input type="checkbox"/> Yes <input type="checkbox"/> No																					
v. Health Details- Height (in Cms) _____; Weight (in Kgs) _____ In the past six months has your weight reduced by 5 kgs or more other than due to diet control exercise or post pregnancy?	<input type="checkbox"/> Yes <input type="checkbox"/> No																					
vi. Provide details of Total Existing Critical Illness cover/Cancer Cover with all insurance companies including LIC:																						
<table border="1"> <thead> <tr> <th>Co. name</th> <th>P&T</th> <th>TYPE - CI/Cancer cover</th> <th>SA</th> <th>DOC</th> <th>Accepted at</th> <th>Inforce / lapsed</th> </tr> </thead> <tbody> <tr> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> </tbody> </table>	Co. name	P&T	TYPE - CI/Cancer cover	SA	DOC	Accepted at	Inforce / lapsed															
Co. name	P&T	TYPE - CI/Cancer cover	SA	DOC	Accepted at	Inforce / lapsed																
Does your Critical Illness cover/Cancer Cover with all insurance companies including LIC exceed INR 5,000,000/- including current application?	<input type="checkbox"/> Yes <input type="checkbox"/> No																					

vii. Have you ever received consultation, medical advice, been investigated, undergone surgery or been treated or have noticed signs and symptoms for following:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
a) Cancer, lump, swelling, growth, nodes, cyst, tumour, non-healing ulcer and increase in size of number of moles anywhere in your body?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
b) Any persistent loss of blood or unusual discharge from any part of the body?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
c) Persistent – fever / headache / cough, difficulty in swallowing, hoarseness of voice (all of the previous symptoms for more than 21 days), visual disturbances, seizures, loss of consciousness, blood disorders, abnormal blood cell count? If yes, please provide details. _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
d) For female Lives Only: Any disease or disorder of the cervix, uterus ovaries or vagina, abnormal bleeding OR any disease or disorder of the Breast(s) such as breast lump/cyst, fibrocystic disease, nipple changes or discharge? If Yes, please provide details _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
viii. Have you or your spouse ever been tested positive for HIV / AIDS, hepatitis B or C or any sexually transmitted disease?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
ix. Other than as a part of routine / executive / pre-employment check-up, Have you been advised to undergo any investigations in last 6 months like ultrasound (USG), body scan, MRI, CT scan, cytology, pap smear, mammogram, colonoscopy, biopsy, blood tests, cancer / tumor markers? If yes, please provide details. _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No

8. QUESTIONS APPLICABLE FOR FEMALE LIVES : i) Husband's Full Name: _____
ii) Husband's existing health insurance cover: SA amount _____ Ins. Co. name: _____ Nature of cover of (CIR, Health Ins, Cancer Cover): _____

IMPORTANT: If answer to any of the above question is "Yes", please provide details (precise diagnosis, past and current treatment, current status, treatment plan for future) in a separate sheet of paper and submit copies of hospital/consultation/investigation reports available with you).

DECLARATION BY THE PROPOSER

I _____ declare that I am fully aware of the statements / contents etc. given by me in this proposal form and confirm that they are true and complete in all respects to the best of my knowledge and that I have not withheld any information and I do hereby agree and declare that the same shall form the basis of the contract and that if any untrue averment be contained therein the said contract shall be dealt with as per provisions of Section 45 of the Insurance Act, 1938 as amended from time to time.

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 Corporation and that the policy will come into force only after full payment of the premium chargeable.

I further agree that any change / addition / deletion / alteration related to my health, occupation, or any other adverse circumstance (including dropping, deferment, acceptance at terms other than as proposed of any proposal/ revival of policy made to the Corporation or any other insurance company) after the submission of this proposal to the Corporation shall be conveyed before the issuance of the First Premium Receipt/ communication of acceptance of risk. Any omission on my part to do so shall render this assurance invalid. I authorize the Corporation to make any enquiry to anyone concerning our health.

I declare that I consent to the Corporation seeking medical information from any doctor or hospital who/which at any time has attended me or from any past or present employer concerning anything which affects the physical or mental health of mine and seeking information from any insurer to whom an application for insurance on my life has been made for the purpose of underwriting the proposal and/or claim settlement.

I authorize the Corporation to share information pertaining to my proposal including the medical records of mine for the sole purpose of underwriting the proposal and/or claims settlement and with any Governmental and/or Regulatory authority.

In consultation with the agent / intermediary, I understood the plan features and have taken a personal and independent decision in an informed manner to go for the Plan. I understand that the 'application money' deposited by me is a token consideration under this proposal for insurance and that the policy will come into force only after full payment of the premium chargeable.

I have read and understood:

(f) PAN Number:

(g) Passport Number:

(h) UID (Aadhaar) Number:

(It is mandatory to provide either PAN No, Passport No or UID No. for availing LIC's e services)

Date : _____

Signature of the Proposer

Place : _____

Name of Proposer : _____

AGENT'S CONFIDENTIAL REPORT/MORAL HAZARD REPORT

Agent's Name & Code	Club Membership	Authorisation No.	Authorisation expiry date	Development Officer Code	Branch Code
Name of Life Proposed	Age	Occupation			
		Nature of duties			
1. (a) Acquaintance with the proposer (No. of Years):					
(b) Relationship with the proposer :					
(c) Educational qualification of the Life Proposed:					
2. Annual Income: Rs..... Income Source..... Proof of Income..... Verified: ..Yes/NoPAN.....					
3. Physical Measurements and Identification Marks of the Proposer and other Members (beneficiaries) to be insured under the proposal.					
Proposer Name	Height (cms)	Weight (kgs)	Abdomen (cms)	Chest (exp/ins) cms	Identification Marks
					1. 2.
4. Are you aware whether LP or any of LP's first degree relatives (which includes the parents, full siblings or children) is/are suffering from Cancer? <input type="checkbox"/> Yes <input type="checkbox"/> No . If YES, give complete details on a separate paper.					

5. Declaration by the Agent

I do hereby declare that I have personally seen the proposer and I do hereby confirm that there is no physical deformity / impaired sight / hearing problem / mental retardation or any other diseases including cancer and am personally satisfied about his / her financial condition. I also declare that I have explained fully the terms and conditions of the plan to the proposer. I further inform that no proposal / revival has been deferred / declined / dropped / accepted with extra premium. I am fully aware that the policy shall be issued based on my above declaration that if any information given above is incorrect, it would attract penalty under Regulation 16 and other provisions of Life Insurance corporation of India (Agents) Regulations, 2017, besides the other provisions of law applicable.

Dated at _____ on the _____ day of _____ 20_____

Agent's Address & Phone No. _____

(Signature of the Agent)

I am fully aware and endorse the above contents; I recommend the proposal for acceptance.

Development Officer / CLIA

Assistant Branch Manager (Sales)/Chief/Sr./Branch Manager.