



Unique Reference Number: CPF/V6.16/022024

"IN UNIT LINKED POLICIES, THE INVESTMENT RISK IN INVESTMENT PORTFOLIO IS BORNE BY THE POLICYHOLDER."

Personal Details of Life to be Insured



PRO50004569610402

LIFE INSURANCE

(Pin Code is mandatory)

 City/District State

 Country Pin Code

 10. a) Name of Organisation /Business/Educational Institution

 b) Nature of industry of the Employer/Organization

 11. Office Address

 Area/Taluka/Tehsil

 City/District State

 Country Pin Code

 12. Education/ MBA LLB Doctor Engineer ICWA/CFA/CS/CA Graduate Post Graduate

 Professional Qualification Std XII Pass Std X Pass Other (Specify) _____

 13. Occupation Salaried Retired Housewife Student Business Owner/ Self Employed

 Non-working

 14. Exact nature of occupation/duties (Specify if you are in money services /lottery/ casino/gambling/horse jockey/NGO/Trust/Charity/Real Estate/Jewelry/Scrap Dealer/Diamond dealer)

 15. Are there any risks associated with the Life to be Insured's occupation? e.g. Working with Boiler, Explosives, Chemicals, etc. Yes No

If Yes, Please fill up the appropriate questionnaire.

16. Annual Income (Rs.) _____

 17. Does Life to be Insured take part in hobbies that are risky in any way? e.g. Aviation, Diving, Mountaineering etc. Yes No

(If Yes, Please submit appropriate questionnaire.)

 18. Is the Life to be Insured a Politically Exposed Person (PEP)? Yes No

(PEPs are individuals who are or have been associated with a political party/politician or holding any senior role in any ministry/government/state owned enterprises/judicial body/military/police in India or abroad or those individuals who have any close family members or associates in the said capacity)

If yes, please provide details _____

 19. Contact Details  : Mobile: ISD Code Number Alternate Mobile: ISD Code Number
 Telephone/Mobile Number wherever available

 Residence number Ph : STD Code Number  Email

Personal Health Details of Life to be Insured

 1. Height ft inches OR cms Weight kgs

 2. Has your weight altered by more than 5 Kgs. in the last 1 year for reasons other than exercise? Yes No

3. Please give the following details

Substance Consumed	Yes/No	If yes, consumed as	Consumption Quantity	For No. of years
Tobacco	Y/N	Cigarette/Cigar/Gutkha/Others	<input type="checkbox"/> Nos per day	<input type="checkbox"/>
Alcohol	Y/N	Beer/Wine/Spirits	<input type="checkbox"/> (ml/week)	<input type="checkbox"/>
Any Narcotics	Y/N			<input type="checkbox"/>

4.1 Please provide medical details as asked in the following questions: (To be filled for Life to be Insured for Life Insurance Product, Major Critical Illness & Heart Cover under Health Product)

Medical Details of Life to be Insured (Applicable for Life Insurance Product, Major Critical Illness & Heart Cover under Health Product)

a.	Have you ever : 1. Been hospitalized for general checkup, observation, treatment or surgery? 2. Been prescribed treatment or medication for a current injury or ailment? 3. Availed more than 5 days continuous leaves on medical grounds in the last 2 years or consulted a doctor/visited a clinic in the past 6 months ? If yes, please provide details 4. Undergone/ Advised X-ray/CT-Scan/MRI/Ultrasound/ECG/Blood Test/any other tests/investigations 5. Undergone/Advised test/tested positive for Hepatitis, HIV/AIDS or any other sexually transmitted disease?	Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/>
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b.	Have you ever suffered or are you suffering from any of the following? 1. Any ailments relating to heart like high/low blood pressure, chest pain, palpitation, rheumatic fever heart attack, shortness of breath ,any other heart disorder or stroke etc. 2. Any ailments related to the brain & nervous system like epilepsy, stroke, depression, mental disorders etc. 3. Tumour, cancer, cyst, abnormal growth or any other malignancy 4. Disorders of eye, ear, nose or throat including defective sight, speech or hearing and discharge from ears 5. Asthma, bronchitis, tuberculosis, difficulty in breathing, persistent cough or any other lung disorder 6. Ailment related to liver, gall bladder, stomach and digestive system like ulcers, stones, colitis, stomach pain, jaundice, hepatitis B or C etc. 7. Any gland related disorder like diabetes/high blood sugar, sugar in urine, thyroid etc. 8. Any kidney system or urinary bladder disorder like stones, nephritis, prostate disorder, reproductive organs etc. 9. Musculoskeletal & joint disorder like gout, rheumatic arthritis, back disorder, Skin disorder etc. 10. Anaemia, disorders of blood (e.g. Haemophilia, Thalassemia) or any other illness not mentioned in (1 to 10) 11. Any physical disability/deformity, congenital disorder, paralysis or multiple sclerosis	Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/>
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Please provide details if answer of any of the above question is answered as "Yes"

Question Number	Details

The Company reserves the right to ask for medical tests or/ seek further information based on above answers.

Please submit Previous Medical Reports (if any) and relevant questionnaire (s)

4.2 Please provide medical details as asked in the following questions: (To be filled for Life to be Insured if Health Product is Opted)

Additional Medical Details of Life to be Insured (Applicable only for Major Critical Illness & Heart Cover)

a.	Have you consulted any doctor for surgical operations or have been hospitalized for any disorder or been advised to undergo/have undergone any medical investigations/treatment for medical conditions other than for minor cough, cold or flu during the last 5 years?	Yes <input type="checkbox"/> No <input type="checkbox"/>
b.	Are you currently taking or in the past have taken any treatment or medications for any condition for a continuous period of more than 14 days? (except for minor cough, cold, flu, appendix, typhoid)	Yes <input type="checkbox"/> No <input type="checkbox"/>
c.	Have you ever availed insurance cover under 'Heart/ Cardiac product/Critical illness cover' through any insurance company in India? If yes, please share details Name of company , Sum Assured	Yes <input type="checkbox"/> No <input type="checkbox"/>
d.	Have you ever suffered from or have been advised that you have any of the following conditions ? 1. High Cholesterol/lipids: 2. Excessive fatigue/syncope/dizziness: 3. Persistent fever or headache:	Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/>
e.	Have you ever had, or been told that you have or are currently undergoing investigation for Abnormal findings in ECG, TMT, CXray, Echo, Angiography or any other cardiac investigations ?	Yes <input type="checkbox"/> No <input type="checkbox"/>
f.	Have any of your immediate family members been diagnosed with prior to age of 60 years from Heart disease, high blood pressure, stroke, Diabetes, kidney disease, cancer or any other disease/ailment?	Yes <input type="checkbox"/> No <input type="checkbox"/>

Please provide details if answer of any of the above question is answered as "Yes"

Question Number	Details

The Company reserves the right to ask for medical tests or/ seek further information based on above answers.

Please submit Previous Medical Reports (if any) and relevant questionnaire (s)

4.3. Please provide medical details as asked in the following questions: (To be filled for Life to be Insured if Health Product is Opted)


Medical Details of Life to be Insured (Applicable when Cancer Cover is opted)

a.	Have you availed insurance cover under "Stand-alone Cancer product" through CANARA HSBC LIFE INSURANCE or through any other Insurer in the Indian insurance market? If answer "Yes" please mention the Sum Assured availed, year of commencement & name of the Insurance Company below	Yes <input type="checkbox"/> No <input type="checkbox"/>
b.	Have you suffered from or been advised investigation/investigated or been treated for any form of Cancer, sarcoma, tumor, or pre-cancerous conditions (few example but not exhaustive are Barrett's esophagus, atrophic gastritis, cervical dysplasia, leukoplakia)	Yes <input type="checkbox"/> No <input type="checkbox"/>
c.	Are you suffering from or ever suffered from, Hepatitis B, Hepatitis C, Liver disease due to alcohol, Barrett's Esophagus, Crohn's Disease, Peptic Ulcer, Ulcerative Colitis?	Yes <input type="checkbox"/> No <input type="checkbox"/>
d.	Have you suffered from or been investigated for any of the following 1. Recurrent cough, hoarseness of voice, or difficulty in swallowing for a continuous period of 15 days? 2. Any persistent loss of blood or unusual discharge from any part of the body? 3. Any ulceration, growth, nodule, cyst or lump in any part of the body?	Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/>
e.	Have you had abnormal findings in any of the listed investigations in the last 6 months (if applicable)- [] Ultrasound [] Endoscopy/Colonoscopy [] CT Scan / MRI [] Biopsy [] PAP Smear [] Mammography [] Blood test for cancer diagnosis (Tumor Marker)	Yes <input type="checkbox"/> No <input type="checkbox"/>
f.	Have any of your parents (below age 60 years), sisters or brothers suffered from any form of cancer	Yes <input type="checkbox"/> No <input type="checkbox"/>
g.	Are you suffering from or ever suffered from HIV/AIDS, Chronic Glomerulonephritis, Chronic Kidney Disease, Polycystic Kidney Disease, Anemia?	Yes <input type="checkbox"/> No <input type="checkbox"/>
h.	Are you suffering from or ever suffered from Fatty liver, Gastritis, Gastro-Esophageal Reflux?	Yes <input type="checkbox"/> No <input type="checkbox"/>

Please provide details if answer of any of the above question is answered as "Yes"

Question Number	Details

The Company reserves the right to ask for medical tests or/ seek further information based on above answers.
Please submit Previous Medical Reports (if any) and relevant questionnaire (s)

To be filled if the Life to be Insured is a Female (For Females only)

1. Maiden Name of the Life to be Insured _____
2. Is the Life to be Insured pregnant at present? Yes No If yes, duration in weeks
3. Did the Life to be Insured ever suffer from or at present suffering from any gynecological related problems? Yes No
4. a. Husband's Name _____
- b. Annual Income _____

Previous Insurance details of Life to be Insured

1. Life Insurance/Health Insurance already In Force/Lapsed/Revival/Applied for (including policies surrendered during the last 3 years) (Please attach additional sheet if necessary with details as mentioned below)

Issuing Life Insurance Company	Years of Issue	Sum Assured (Rs)	Annual Premium (Rs.)	Riders if any	Acceptance Terms (Std./With Med Extra/With Non Med Extra)

2. Has a proposal on Life to be Insured's life ever been withdrawn/postponed/declined/dropped or accepted with modified terms /extra premium or has Life to be Insured ever made any claim under a policy of Life/Health Insurance? Yes No
If yes, please give details _____

Family Health Details of Life to be Insured

Please furnish details of family members of the Life to be Insured. Also in case of any family members suffering or having suffered or died of heart disease, stroke, high blood pressure, diabetes, any form of eye disease, kidney disease, paralysis or any hereditary/familial disorders, any communicable disease, or any disease not mentioned above, mention the same in the following table. If the Life to be Insured is not aware, please leave it blank, the Company could ask for clarifications later. Please attach additional sheet if necessary with details as mentioned below.

Family Member	If Alive		If Deceased	
	Current Age	Mention the name of disease/illness (if any)	Cause of Death	Age at Death
Father				
Mother				
Spouse				
Brother(s)				
Sister(s)				

Nominee Details

Note: Nominee/Beneficiary details to be provided, only where Life to be Insured is proposing on self (In case of Multiple Nominees/ Beneficiaries, please fill up Multiple Nomination Form)

2. a) Date of Birth DD/MM/YYYY b) Gender Male Female Transgender

3. Nominee Relationship with Life to be insured Spouse Son Daughter Father Mother Other (Specify) _____

Area/Taluka/Tehsil

City/District _____ State _____

Country Pin Code

1. Name of Appointee/ Guardian Title Mr. Mrs. Ms. Other (specify) _____

2. a) Date of Birth / / DD/MM/YYYY b) Gender Male Female Transgender

3. Relationship with the Nominee/Beneficiary

4. Address of Appointee/Guardian _____

Area/Taluka/Tehsil

City/District _____ State _____

Telephone/Mobile Number wherever available

5. Contact details Mobile with ISD code _____ Alternate Mobile ISD code _____

Residence Ph: <img alt="Home icon" data-bbox="8673 937 8688 95

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I would like to opt for Plan Option*¹¹ : Endowment Option {{Optional benefit Payor Premium Protection Cover Accidental Death Benefit}} Regular Income Option {{Optional benefit Payor Premium Protection Cover Accidental Death Benefit}} Early Income Option {{Optional benefit Accidental Death Benefit}} {Income Period 19 29 39} Long Term Income with Return of Premium Option {{Optional benefit Accidental Death Benefit}} {Income Period 15 20 30 40}}

I would like to opt for Income Frequency*¹¹: Monthly Yearly

*if opted, please fill second life questionnaire

Coverage options for Health First Plan:

Modified Common Proposal Form

I would like to opt for: Major Critical Illness Cover {Type of cover Level Sum Assured Increasing Sum Assured} { Monthly Income Benefit Option} { Return of Premium Option}

I would like to opt for: Heart Cover {Type of cover Level Sum Assured Increasing Sum Assured} { Monthly Income Benefit Option}

I would like to opt for: Cancer Cover {Type of cover Level Sum Assured Increasing Sum Assured} { Monthly Income Benefit Option}

(Note: Return of Premium Option under Major Critical Illness Cover is available for policy term 10 years to 20 years only.

For Unit Linked Plans*:

Plan Name	I would like to opt for								
Invest 4G	<input type="checkbox"/> Life Option <input type="checkbox"/> Care Option <input type="checkbox"/> Century Option								
Wealth Edge	<input type="checkbox"/> Invest Plus <input type="checkbox"/> Premium Plus <input type="checkbox"/> Life Plus								
Alpha Wealth	<input type="checkbox"/> Alpha Invest Plus <input type="checkbox"/> Alpha Premium Plus <input type="checkbox"/> Alpha Life Plus								
Promise4Growth	<input type="checkbox"/> Promise4Wealth <input type="checkbox"/> Promise4Care <input type="checkbox"/> Promise4Life								

| <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> % |
|--|--|--|--|--|--|--|--|--|--|
| Emerging Leaders Equity Fund | India Multi Cap Equity Fund | Midcap Momentum Growth Index Fund | Equity II Fund | Growth Plus Fund | Balanced Plus Fund | Large Cap Advantage Fund | Debt Fund | Debt Plus Fund | Liquid Fund |

The SFIN (Segregated Fund Index Number) for: Emerging Leaders Equity fund is ULIF02020/12/17EMLEDEQFND136, India Multi-Cap Equity Fund is ULIF01816/08/16IMCAPEQFND136, Midcap Momentum Growth Index Fund is ULIF02218/03/24MIDMIEQFND136, Equity II Fund is ULIF00607/01/10EQUTYIIFND136, Growth Plus Fund is ULIF00913/09/10GROWTPLFND136, Balanced Plus Fund is ULIF01013/09/10BLNCDPLFND136, Large Cap Advantage Fund is ULIF02109/06/20LARCPADFND136, Debt Fund is ULIF00409/07/08INDEBTFUND136, Debt Plus Fund is ULIF01115/09/10DEBTPLFUND136 & Liquid Fund is ULIF00514/07/08LIQUIDFUND136.

Premium Funding Benefit Option Chosen* Death Only Death Or TPD

You can select your option(s) from the following*

Auto Funds Rebalancing Milestone Withdrawal Option (MWO) @ Safety Switch Option
 Systematic Withdrawal Option (SWO) @, Choose Frequency of SWO Monthly Quarterly Half-yearly Yearly

Fund Value to be withdrawn in a Policy Year _____ (1% to 12%)

Systematic Transfer Option, Choose Target STO Fund India Multi-cap Equity Fund Equity II Fund Emerging Leaders Equity Fund Large Cap Advantage Fund

Return Protector Option, Choose RPO Fund <India Multi-cap Equity Fund/ Equity II Fund/ Emerging Leaders Equity Fund/ Large Cap Advantage Fund>

Target Appreciation _____ % (5% to 15% in multiple of 1)

@Only one of 'Milestone Withdrawal Option' or 'Systematic Withdrawal Option' can be chosen.

For Pension Plans:

Annuity option at the time of vesting (maturity) (Please mention Annuity option code as mentioned below)

01	Immediate Life Annuity	02	Immediate Life Annuity with Return of Purchase Price	03	Immediate Life Annuity with Return of Balance Purchase Price
04	Immediate Life Annuity with Return of Purchase Price on Critical Illness (CI) or Accidental Total & Permanent Disability (ATPD) or Death	05	Immediate Joint Life Annuity with Return of Purchase Price	06	Deferred Life Annuity with Return of Purchase Price Deferment Period– <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> 9 <input type="checkbox"/> 10 (years)

A. Amount to be annuitized (as a %age of vesting amount): _____ % (min 40%)

B. Amount to be annuitized from other insurer (as a %age of A above): _____ % (max 50%)

Other Insurer: _____

* Please refer sales brochure for details on option(s)/ Unit Linked Fund(s) available under a particular product.

¹ Applicable for Jeevan Nivesh Plan; ² Applicable for Jeevan Nivesh Plan, Invest4G, Smart Goals Plan, Smart Future Plan, Wealth Edge, Alpha Wealth, Promise4Growth;

³ Applicable for Guaranteed Savings Plan; ⁴ Applicable for Guaranteed Income4Life; ⁵ Applicable for Guaranteed Suraksha Kavach; ⁶ Applicable for Flexi Edge; ⁷ Applicable for iSelect Guaranteed Future; ⁸ Applicable for Guaranteed One Pay Advantage; ⁹ Applicable for Guaranteed Fortune Plan; ¹⁰ Applicable for Guaranteed Assured Income; ¹¹ Applicable for iSelect Guaranteed Future Plus

Mode of Renewal Premium Payment

Preference for Renewal Premium Payment

Cheque/Demand Draft Standing Instructions/NACH Credit Card Others _____

Please fill Payor Questionnaire, Payor KYC and AML Questionnaire if Payor different than Proposer



Bank Details of Proposer for receiving refund or payments

I hereby request you to transfer all refunds / payments arising from the stage of proposal until the completion of tenure of the policy, directly to the bank account, details of which are provided herein below.

Note - Please submit relevant supporting documents along with the below details

Account Holder Name _____	First Name _____	Middle Name _____	Last Name _____	
Bank Name _____				
Account No. _____	IFSC Code _____			
Branch Address _____				
Account Type	<input type="checkbox"/> Savings	<input type="checkbox"/> Current	<input type="checkbox"/> NRE	<input type="checkbox"/> NRO

Declaration and Authorization

- I hereby declare, on my behalf and/or on behalf of Life 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 the Life Insured.
- 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.
- I/We hereby authorize Company to send me any information relating to my proposals / policies through SMS on the phone number/email address provided by me.
- I have selected the product on voluntarily basis my needs and affordability and also hereby agree that any failure on my/our part to notify the Company of the required information or if any of the statements, answers and declarations are found to be fraudulently made or amount to mis-statement, the said contract shall stand terminated and benefits payable under the Policy will be as per applicable laws including Section 45 of the Insurance Act, 1938, as amended from time to time.
- I authorize the Company to conduct screening/confirmation/reconfirmation of overall status of my as well as that of the Life to be Insured including the health status through medical examinations, if required, which may include Laboratory tests, Cardiac, Radiological investigations and other medical tests including blood tests to detect bacterial/viral/fungal infections. I hereby give my consent to undergo HIV1/2 test by ELISA method. I am aware that this test is only for screening purposes and not confirmatory for HIV/AIDS.
- I/We authorize the Company to share (within or outside India) my or life to be Insured's information regarding the financial, physical or mental health together with leave records, employment details from/ with (i) Governmental and/or Regulatory Authority, (ii) Insurance Repositories (iii) CERSAI/ other authentication agencies (iv) reinsurers//hospitals or diagnostic centers/other insurance companies including any past or present employer for underwriting assessment, claim investigation/ settlement, KYC authentication (if permitted), offline verification and policy servicing purpose as per regulatory framework put in place by the Authority.
- I hereby consent to receive the information from Central KYC Registry or other statutory authority through sms/email on the registered number/email address.
- I/We declare that the premiums paid/ payable are/will not be generated from the proceeds of any illegal means/criminal activities / offences and I/we shall abide by and conform to the Prevention of Money Laundering Act, 2002 or any other applicable laws. I understand that in case of withdrawal of this application by me post undergoing medicals or part thereof, the Company shall return the first premium deposit without any interest and after deducting the expenses incurred on the medical test/examination, if any.

In case of Thumb Impression, Left Thumb Impression (LTI) for Males, and Right Thumb Impression (RTI) for Females




Signature/Thumb Impression of Life to be Insured
(Proposer signature required if Life to be Insured is a minor)

Date DD/MM/YYYY

Signature/Thumb Impression of Proposer

Place _____

Foreign Account Tax Compliance Act ("FATCA")/Common Reporting Standards ("CRS") Declaration (**Applicable if the proposer is a US person or is a tax resident outside of India**):

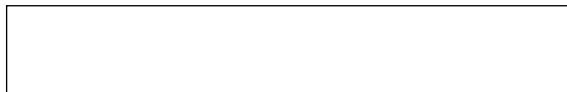
- I/we certify that (a) I am taxable as a US person under the laws of the United States of America ("U.S.") or any state or political subdivision thereof or therein, including the District of Columbia or any states of the U.S., or (b) an estate the income of which is subject to U.S federal income tax regardless of the source thereof. (This clause is applicable only if the proposer is identified as a US person); or (c) taxable as a tax resident under the laws of country outside India. (This clause is applicable only if the proposer is a tax resident outside of India)



LIFE INSURANCE

ii. I/We understand that the Company is relying on the information submitted by me for the purpose of determining my status in compliance with FATCA/CRS. The Company is not able to offer any tax advice on CRS or FATCA or its impact on me. I/We shall seek advice from professional tax advisor for any tax questions. I/We agree to submit a new form within 30 days if any information or certification on this form becomes incorrect. I/We agree that as may be required by domestic regulators /tax authorities, the Company may also be required to report, reportable details to CBDT or close or suspend my policy. I/We certify that I/We provide the information on this form and to the best of my/our knowledge and belief the certification is true, correct, and complete including the taxpayer identification number.

In case of Thumb Impression, Left Thumb Impression (LTI) for Males, and Right Thumb Impression (RTI) for Females




Signature/Thumb Impression of **Life to be Insured**
(Proposer signature required if Life to be insured is a minor)

Date DD/MM/YYYY

Signature/Thumb Impression of **Proposer**

Place _____

Declaration by Insurance Intermediary's Representative/ Direct Sales Person/ Agent, etc

I _____ have suggested the present product (s) to the Proposer basis the assessment of suitability thereof to the needs of the proposer and have fully explained all the features thereof to the Proposer and he/she has understood same.



Signature of Insurance Intermediary's Representative/Direct Sales Person/Agent, etc

Vernacular language/Proposal not filled by Prospect/Illiterate Declaration:

I _____ Son/Daughter of _____, adult and residing at _____ do hereby declare on solemn affirmation as under: I have read out and fully explained the contents of the proposal form in _____ language to Mr./Mrs./Ms. _____ and he/she has understood the significance of the proposed contract. I have truthfully and correctly recorded the replies given by the Proposer/Life to be Insured and that the Proposer/Life to be Insured has affixed the signature/thumb impression above, after fully understanding the contents thereof. Solemnly affirmed at _____ on _____

I _____ (Proposer) hereby declare that I have understood the questions and answers of the proposal form as explained by Insurance Intermediary's Representative/Direct Sales Person/Agent/Declarant.

Signature of Insurance Intermediary's Representative/Direct Sales Person/Agent/Declarant



Signature/Thumb Impression of Proposer

Your communication address is very important for better service. Please check it thoroughly before signing

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

1) No person shall allow or offer to allow, either directly or indirectly, as an inducement to any person to take out or renew or continue an insurance in respect of any kind of risk relating to lives or property in India, any rebate of the whole or part of the commission payable or any rebate of the premium shown on the policy, nor shall any person taking out or renewing or continuing a policy accept any rebate, except such rebate as may be allowed in accordance with the published prospectuses or tables of the insurer.

Section 45 of 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 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 the 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 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 of fraud: 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 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 a 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 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 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:

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 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 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 sections 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.

Proposal Acknowledgment

Proposal Number: 5000456961

I, Mr/Ms _____ have received the proposal for life insurance along with (Rs.) _____ from Mr/Ms _____ towards proposal deposit by the way of Cheque/DD No. _____ drawn on _____ dated _____ with Canara HSBC Life Insurance Company Limited, _____ branch.

This slip is not your premium receipt. The premium receipt will be issued only on receipt of premium by the Insurer and upon application of the premium to your policy subject to acceptance of risk. Receipt of completed proposal and initial premium does not create any obligation upon the insurer to underwrite the risk. Risk under the policy will not commence till the Insurer accepts the proposal, underwrite the risk and communicates to you the acceptance of the risk on this proposal by issuing the policy.

Details of Insurance Intermediary's representative/Direct Sale Person/Agent

Name _____

Code _____

Date / / MM/DD/YYYY

Signature

Canara HSBC Life Insurance Company Limited
(formerly known as Canara HSBC Oriental Bank of Commerce Life Insurance Company Limited) **IRDAI Regn. No. 136**
Head Office Address: 139 P, Sector 44, Gurugram – 122003, Haryana, India
Registered Office Address: 8th Floor, Unit No.808 - 814, Ambadeep Building, Plot No. 14, Kasturba Gandhi Marg, New Delhi 110001
Corporate Identity No: U66010DL2007PLC248825

 Call us at 1800-103-0003/1800-180-0003/1800-891-0003

 SMS at 7039004411

 E-mail us at customerservice@canarahsbclife.in

 Visit our website at www.canarahsbclife.com