(PLI-01)

Affix Passport Size Photograph

DEPARTMENT OF POSTS
PROPOSAL FORM FOR RURAL POSTAL LIFE INSURANCE (MEDICAL)

FOR OFFICE USE ONLY

Name of the Development Officer/FOs/Agent/ Postal employees (ASP/ IPO/PM/ PA/ SA/ Postman/Mail guard/GR'D/GDS-BPM/GDS-DA/ GDS-MC)

Agent Code

Proposal No.

Date of receipt

No. of PLI-2

Amount deposited ₹

Post Office at which deposited

ACG- 67 Receipt No and Date

Policy No.

Date of obtaining proposal by BPM

Date of receipt of proposal at Divisional office

IMPORTANT NOTE

1. THIS FORM IS MEANT FOR INSURANCE OF ONE LIFE ONLY.
2. PROPOSER SHOULD MAKE HIM/ HERSELF FAMILIAR WITH TERMS AND CONDITIONS AND RULES OF THE SCHEME BEFORE FILLING IN THE FORM EITHER HIMSELF OR THROUGH HIS AGENT.
3. ALL ANSWERS SHOULD BE FILLED IN LEGIBLY. DOTS, DASHES OR BLANKS WILL NOT BE ACCEPTED.
4. PROPOSER SHALL BE RESPONSIBLE PERSONALLY FOR THE INFORMATION FILLED IN THIS FORM IRRESPECTIVE OF WHETHER THE FORM IS FILLED IN HIS OWN HAND OR THROUGH HIS AGENT. ATTENTION IS INVITED TO RULE 7 OF POIF RULES FOR INACCURATE, WRONG OR MISLEADING INFORMATION GIVEN BY THE PROPOSER WHICH MAY RESULT INTO CANCELLATION OF THE POLICY AND FORFEITURE OF ALL MONEYS PAID BY THE PROPOSER.

All entries should be filled in capital letters:

1. Name

2. Date of Birth

Age on next birth day

Nature of proof of age

Place of Birth

3. PH Code

4. Sum Assured ₹

5. (a) Type of Policy

(b) Term

6. Age at Maturity

7. BPO Pin code

8. BPO Code

9. BPO Name

10. Division

11. Region

12. PAO Sub code

13. Date of proposal

14. Date of Declaration

15. Permanent Address

Pin code

Mobile Number

16. Address Details for Correspondence

Pin code

17. If policy is proposed to be taken under Married Women Property Act 1874, state object particulars of beneficiary and particulars of trustee. **(Nomination in such cases not allowed)**

18. If policy is being funded by HUF give particulars of HUF.

19. Nomination (refer section 39 of Insurance act 1938) (Not applicable in case of policy under MWPA 1874)

a. State particulars of the nominees (not more than three Nominees)

Sole/ First Nominee Details-

Name

Address

Pin code

Relationship

Age

% Share of claim amount

Second Nominee Details-

Name

Address

Pin code

Relationship

Age

% Share of claim amount

Third Nominee Details-

Name

Address

Pin code

Relationship

Age

% Share of claim amount

b. **Appointee Details(if nominee is minor)**

Name

Address

Pin code

Relationship

Age

20.. Father's/Husband's Name

21. Maturity Date

22.. Educational Qualification

23.Occupation and Income Particulars

24.. Are you income tax payee ? Yes No

25. Premium Amount ₹

26. (a) Mode of Payment Cash Cheque

(b) Periodicity M Q HY Y

27. (a) Do you hold any other Rural Postal Life Insurance Policy? If so, give details:

	Policy No.	Type	Sum Assured (in ₹)
Proposer: -	1.		
	2.		
	3.		
		Total:	

28. Has any of your proposals been earlier rejected or extra premium levied thereon by any insurer? Give details.

____

____

29. Family history:

Has any of your family members (living or dead) suffered from any hereditary or infectious disease like Insanity/ Epilepsy/ Gout/ Asthma/ Tuberculosis/ HIV/ Cancer/Leprosy/ Diabetes etc.

(Note: The term family includes Mother, Father, Brothers & Sisters.)

30. (a) Are you at present in sound health? Yes No

(b) Have you ever suffered from any of the following diseases?

(i) Tuberculosis	:	Yes	No
(ii) Cancer	:	Yes	No
(iii) Paralysis	:	Yes	No
(iv) Insanity	:	Yes	No
(v) Any disease of heart and lungs	:	Yes	No
(vi) Kidney disease	:	Yes	No
(vii) Any disease of brain	:	Yes	No
		Yes	No
			No

(viii) Diabetes :

(ix) Hypertension : Yes No

(x) HIV Positive : Yes No

(xi) Hepatitis-B : Yes No

(xii) Epilepsy : Yes No

(xiii) Nervous disorder : Yes No

(xiv) Liver : Yes No

(xv) Leprosy : Yes No

(xvi) Any physical deformity or handicap : Yes No

(xvii) Any other serious disease : Yes No

(c) Have you availed of any kind of leave on medical ground or hospitalized during the last 3 years? If so, furnish the following information.

	Kind of leave	Period of leave	Ailment	Name of Hospital	Period of Hospitalization	
					From	To
1.						
2.						
3.						

(d) Particulars of the family doctor, if any:____________________

For Female Proposers Only

31. (a) Marital status

(b) No. of children

(c) Date of last delivery

(d) If pregnant, then expected month of delivery

32.Mark of Identification (Two)

(a)															
(b)															

Signature of Appointee

For medical Cases only

I certify that the proposer has signed / put his/her thumb impression in my presence, after admitting that all the answers to question No 30 and onwards of form have been correctly recorded.

Signature or thumb impression of the proposed
NB- Signature or thumb impression should be affixed in the presence of medical examiner

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Signature of the medical examiner

Designation:
Seal:
Date:
Doctor's Code:

DECLARATION BY THE PROPOSER

I hereby declare that the foregoing statements and answers have been given by me after fully understanding the questions and the same are true and complete in all respects and that I have not withheld any information and I do hereby agree and declare that these statements and this declaration shall be the basis of the contract of assurance between me and the Department of Posts and that if any untrue averment be contained therein, the said contract shall be absolutely null and void and all moneys which shall have been paid in respect thereof shall stand forfeited to the Department.

Notwithstanding the provision of any law, usage, custom or convention for the time being in force prohibiting any doctor, hospital and / or employer from divulging any knowledge or information about me concerning my health or on the grounds of secrecy I, my heirs nominee, executors, administrators and assignees or any other persons or persons having interest of any kind whatsoever in the policy contract issued to me, hereby agree, that such authority, having such knowledge or information shall at any time be at liberty to divulge any such knowledge or information to the Department.

And I further agree that if after the date of the submission of the proposal but before the acceptance of the proposal, (i) any change in my occupation or any adverse circumstance connected with my financial position or the general health of myself or that of any member of my family occurs or (ii) if a proposal for assurance or an application for revival of a policy on my life made to any office of the Department has been withdrawn or dropped, deferred or declined or accepted at an increased premium or subject to a lien or a term other than as proposed, I shall forthwith intimate the same to the Department in writing to reconsider the terms of acceptance of assurance. Any omission on my part to do so shall render this assurance invalid and all moneys which shall have been paid in respect thereof forfeited to the Department.

a) The contents of surrender table and instructions for admissibility of surrender value have been explained to me before taking policy and I abide by the same.
b) Surrender of a policy is not admissible before completion of thirty six months of the policy and the amount deposited shall be forfeited if I surrender the policy without paying premiums for thirty six months.
c) On surrender, the policy shall attract proportionate bonus on reduced sum assured up to the date for which premium has been paid. However, no bonus shall be payable before completion of 5 years of the policy.
d) The discontinued policy shall not attract bonus with effect from the date from which the premium is discontinued.
e) The reduced sum assured shall be calculated by multiplying the sum assured with the number of instalments paid and dividing the same with the total number of premiums to be paid.
f) The surrender value shall be calculated by multiplying the sum of reduced sum assured plus the proportionate bonus, if any, with the surrender factor as applicable on the attained age on the date of surrender of the policy.

____
Signature of witness

Name _____________________ Occupation _____________________

Address ____

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

Note : If in this form the answers to the questions and / or signature of the proposer hereinabove are/is in vernacular then he/she should declare above his/her signature in his/her own handwriting that the replies are given after fully and properly understanding the same.

Declaration by the person filling in the form

Declarant's Name _______________________________

Address _______________________________________

____

____

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

____
Signature of Agent or the person filling the proposal form

Date : ________________________

Declaration in case the proposer is illiterate

Note : In case the proposer is illiterate the thumb impression of the proposer should be attested by a person of standing whose identity can easily be established but unconnected with the Deptt. and this declaration should be made by him.

I hereby declare that I have explained the content of this form to the proposer in …………………. ……………………… (Language) which he/she easily understands and that the proposer has affixed the thumb impression above after fully understanding the contents there of

Declarant's Name ………………………………………………..

Address …………………………………………………………..

Signature …………………………………………………

Date ……………………………………………………

Confidential Report

This will consist of information not revealed in the proposal form. SDI/ ASP report is not only required for granting a policy but will also be required when claim arises, to check the correctness of data in proposal form. This will be completed by SDI/ ASP after proposal form is completed by proposer. Content of the report should not be discussed with the proposer or divulged to him.

(The form should be completed by SDI/ASP)

1. Are you related to the proposer? : | Yes | NO |

2. Are you aware of any financial/physical/mental situation concerning proposer which makes him unsuitable for consideration of his Insurance proposal? : | Yes | NO |

3. In case of any doubt, please visit the concerned police station and verify if the proponent was ever arrested/ convicted in the criminal case. If yes, give details. : | Yes | NO |

4. Has he signed proposal/Declaration form? : | Yes | NO |

5. Any other matter you would like to bring to the notice of Proposal accepting authority. : | Yes | NO |

6. Do you recommend the acceptance of the proposal? : | Yes | NO |

7. If not recommended, give reasons. : | Yes | NO |

8. Please confirm that :-

   (1) Confidential report has been written by you after completion of proposal form by proposer. : | Confirmed | Not Confirmed |

   (2) Confidential report has not been divulged to proposer/or discussed with him. : | Confirmed | Not Confirmed |

Signature SDI/ASP
Full Name With Stamp