

State

DEPARTMENT OF POSTS PROPOSAL FORM FOR RURAL POSTAL LIFE INSURANCE

Affix here your recent passport size photograph

All entries should be filled in CAPITAL letter: **FOR OFFICIAL USE ONLY** Name of the Development Officer/ FO/ Agent/ Postal Proposal No. Employee (ASP/ IPO/ PM/ PA/ SA/ Postman/ Mail Guard/ MTS/ GDS BPM/ GDS DA/ GDS MC) **Date of Receipt** No. of LI-7(a) Amount deposited ₹ Agent Code Post Office at which deposited ACG-67 Receipt No. and Date Policy No. Date of Declaration (DD/MM/ Proposal Date (DD/MM/YYYY) 1 1 Product/ Policy Type AEA WLA CWLA EΑ GΥ 1. Proposer's Details i. Name of Proponent (Mr./ Mrs./ Ms.) ii. Father's Name iii. Spouse Name (If proponent is married) vi. Date of Birth (DD/MM/YYYY) iv. Gender v. Marital Status (Married/ Unmarried) F 1 1 M vii. Age Proof: [Tick (√) whichever is applicable] (Standard Age Proof) Matriculation Certificate Driving License Passport PAN Birth Certificate Certificate extract from Service register in the case of Govt. Employees Identity card issued by Defence Department No. (Non-Standard Age Proof) Elder's Declaration Horoscope Aadhaar Card Medical Examiners Approximate age certificate Dec by insurant counter signed by Panchayat Member Only month year of Birth is known viii. Nationality ix. FOR FEMALE PROPONENT ONLY Number of Are you Pregnant Date of last Delivery Children now? (Yes/No) Date of Last Menstruation If pregnant, expected month of delivery Have you had any abortion or miscarriage or caesarean section? If so, give details. x. Mark of Identity (1) Mark of Identity (2) 2. Proposer's Address Details i. Communication Address (If Permanent Address is same as Communication Address please √ in the box Village Taluka City District PIN State Country ii. Permanent Address Village Taluka City District

Country

PIN

3. Proposer's Contact Details i. Phone No. with STD Code	ii. Mobile No.
iii. E-mail ID (If any)	
4. Proposer's Occupation and Income Details i. Occupation	
Agriculture Teacher Carpenter Labour Tai	ilor Blacksmith Doctor Cobbler
Fisherman Postmaster Goldsmith Canner Price	est Mason Porter Electrician
Housewife Weaver Dhobi Barber Milk vendor	Business Vegetable vendor Driver
Mechanic Mid wife Govt employee Private employ	vee Un-employed Student Taper
Toddy worker Other (Please specify)	
ii. PAN No.	T.T.
iv. Occupational Address	-
Village Taluk	(a
City Distri	ict
State Coun	
v. Phone No. with STD Code vi. E-mail ID (If any	<u>,</u>
vii. Qualification	
Post Graduate Diploma Se. Sec. Education	High School Middle Class Primary Education
Illiterate Other Detail	
5. HUF Details (If applied under HUF)	
Give particulars of HUF like Name of Karta, PAN No. of Karta, C Names, Relationship with Karta, Age of Member's/ Coparceners N	
signature and addresses on a separate page.	arries with flames of two (2) withesses with their
6 A. Particulars of beneficiary, if policy is proposed to be tak	en under Married Women Property Act 1874
(Nomination in such cases not allowed)	
Give details of beneficiary(ies) (maximum three) like Beneficiary Na minor or not, %age of their share (if more than one beneficiaries) on	
6 B. Particulars of trustee, if policy is proposed to be taker (Nomination in such cases not allowed)	n under Married Women Property Act 1874 .
Give details of Trust like Individual or Corporation, Name of Trust, N	Name of Trustee (only in case of Individual Trust).
Trustee Relationship, Communication address, Trustee Phone No. at	
7. Nomination Details (refer Section 39 of Insurance act 1938) (Not appl	icable in case of policy under MWPA 1874)
a. State particulars of the nominees (not more than three Nominees)	
i. Sole/ First Nominee Details- (Mr./ Mrs./ Ms.)	
First Name Middle Name	Last Name
Relationship: Brother Sister Son Daughter	Mother Father Spouse
Father-in-law Mother-in-law	Others
Share %age:	
Date of Birth: / / / Age:	Years
Communication Address	
	
Village Talul	
City Distri	
Phone No. E-mail ID (If any)	

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i. Pren	verage Details hium Ceasing Age/ at Maturity Years	ii. Policy T	erm Years	iii. Sum A	Assured			
i. Pren ₹		1 -	Premium Paym		ue/ Credit Card/ Debit C		Premium Payment M	lode
iv. Pre Month	mium Payment Fre lly Qua	quency: rterly	Half Ye	early	Yea	rly		
	roponent's Heal you in sound health			Yes _	No			
b. Hav	e you ever suffered	/ suffering from a	any of the follow	wing? (Sa	•	nent		
	Kidney disease Any disease of HIV Positive Hepatitis-B Epilepsy Nervous disord Liver Leprosy Any physical de Any other serice	brain der eformity or handing disease / members (Fatl	ner, Mother, B			No N	ed from any heredit	ary or infectious
	give details:							
d. Hav		kind of leave	on medical gr	round or I	nospitalized du	uring the last 3	years? If so, furni	sh the following
	Kind of leave	Period of leave	Ailment		Name of Ho	spital	Period of Hos	spitalization To
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2. 3.								
	vou bovo ony nhyoi	aal dafarmity or (ongonital by b	irth defect	n2 (Van/ Na)			
ii. In ca		eformity, please s	state whether it	is Blindne	ess/ Deafness/	Dumbness/ Orth	nopedic Handicap of	
	ase of non-congeni					ness/ Dumbness	s/ Orthopedic Handid	ap of One Limb/
Menta		mental age of	14 or above/ V	Veakness	or deformity/	Paralysis due to	ap of both Limbs/ Lo o Polio/ Any other d	
f. Parti	culars of the family	doctor, if any:						

12. Declaration of Proponent

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
- 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 within 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.

	Proponent's Signature:
Dated: The Day of 2	0
Declaration by the pe	rson filling in the form
Declarant's Name	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	ne 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 Depti and this declaration should be made by him	to the proposer in
	Signature Declarant's Name
	Address
	Date
13. To be filled in by DO/ FO (PLI)/ Agent	
I Agent Code No./ I in the proposal form has been furnished by the proponent and it hopresence. All columns have been completed and are correct and acceptance.	D certify that the information as been signed by him/ his thumb impression has been taken in my no question is left un-answered. The proposal is recommended for
Date:	Agent's Signature:
14. Medical Examiner's Certificate: Certified that I have carefully examined Shri/ Smt.	
·	the Day of
20	
On careful examination of the proponent and after going through proponent to be medically fit. He/ She does not suffer from any ter life. I recommend acceptance of his/ her proposal of Postal Life Ins	the information furnished by him/ her under column 11, I find the minal or other serious health hazard which would be risk to his/ he surance policy.
The proponent is medically unfit. I do not recommend acceptance	DR of his/ her proposal for Postal Life Insurance policy.
, ,	, .,
Signature of Proponent:	Signature of Medical Examiner:Name:
	Seal:

ID/ Code : _

NOTE FOR MEDICAL OFFICER

- a) If the proponent is overweight or has doubtful family history an electrocardiogram and a report on the scanning of the chest would be required.
- b) If the proponent is underweight and has family history of TB, an X-Ray of the chest would be required.
- c) Expense of the above mentioned tests will have to be borne by the proponent.

15. 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	
3.	Do you recommend the acceptance of the proposal?	:	Yes	No	
7.	If not recommended, give reasons.	:	Yes	No	
3.	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	

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Signature of SDI/ ASP Full Name With Stamp