Double Suraksha UIN: MAGHLIP25035V012425



Double Suraksha Proposal Form

	Proposal No	
	·	
1. FOR OFFICE USE ONLY		
Branch Name	Branch Code	
Intermediary Name	Intermediary Code	
Sales Channel Type	If POSP then please provide the below:-	
Proposal Received On	a) PAN Card Number of POSP: b) AADHAR Card Number of POSP:	

GUIDELINES FOR COMPLETION OF THE FORM (TO BE FILLED BY PROPOSER)

Please answer all the questions fully and correctly. This proposal will be the basis of any insurance policy that We may issue. You must disclose all facts relevant to all persons proposed to be insured that may affect Our decision to issue a policy or its price, terms, conditions and exclusions. The policy shall become void at Our sole discretion, in the event of any untrue or incorrect statement, misrepresentation, non-description or non-disclosure in any material particular in the proposal form/personal statement, declaration and connected documents or any material information having been withheld by the Proposer or anyone acting on his behalf.

If there is insufficient space for you to provide information whether as requested or otherwise, please attach a separate sheet. If you are in any doubt, please seek the help of Our company representative or your insurance advisor. If We accept a proposal for insurance, it shall be subject to the Policy terms and conditions, and We shall have no liability to make any payment under the Policy if premium is not received by Us in full and in time or is not realized or non-fulfillment of pre-policy medical check-up or proposal is not accepted by Us.

is not accepted by es.			
All fields/details marked with * ar	e mandatory.		
2. PROPOSER DETAILS			
Please fill up this form in CAPITA	AL LETTERS for yourself and each proposed insu	red person.	
Proposer Name*			
(Mr./Ms./Mrs./Other)			
		Middle Name)	(Last Name)
Marital Status		Married	
Gender	_ -	Female	☐ None of these
Nationality* Occupation	□ Salaried □ Self-employed	Professional	Others (please specify)
Annual Income (in ₹)	□ < 3,00,000 □ 3,00,000 − 10,00		
Address for Correspondence*	3,00,000 - 10,00	10,00,001 = 2	3,00,000
, idar ess rei Gerresperraerres			
Landmark			
City:	State:		Pin Code:
Phone No. STD Code L	andline No. Mobile No	.* E	mail ID
Are you a Magma HDI General I	nsurance Company Limited Employee? 🔲 Yes	☐ No	
Do you have any other Policy with	n Magma HDI General Insurance Company Limite	ed: If yes, Employee ID:	
PAN No	Passport No		Voter's Card No
Driving License No	Aadhaar number No		CKYC No
		starts and / Division Linears / And	
Please share ID and address proof for	KYC purpose. If Pan is provided, please share Passport / Vo	ofer's cara / Driving License / Addi	naar number or any other officially valid document.
3. PLAN DETAILS*			
Policy Type	Individual 🔲 Family Floater	Policy Period	1 Year 2 Years 3 Years
If Family Floater*, number of per	sons to be covered:	Premium Payment	☐ Single Premium ☐ Quarterly Instalment
Adults: Children:	(* - Max 4 Adults and 3 children)	Frequency	☐ Monthly Instalment ☐ Half Yearly Instalment
Per Day Sum Insured 1	,000 / 2,000 / 3,000 / 5,000 / 7,000 / 10,000 P	er Dav	
,	0 days/ 60 days / 90 days / 120 days / 180 days		
, ,	· · · · · · · · · · · · · · · · · · ·		
	Optional Cover Name		Opted / Not Opted
Convalescence benefit	Opholia Cover Hame	Yes No	Opica / Not Opica
Day Care Treatment Cash		Yes No	
Childbirth Hospital Cash		Yes No	
Worldwide Hospital Cash		Yes No	
Companion Benefit			
· .		Yes No	
Pre-Post Hospitalization Expenses		Yes No	
Increase in Deductible Sickness H	•	Yes No	
Reduction in Deductible Sickness	<u>'</u>	Yes No	
Increase in Max days for ICU Ber Health Maintenance Benefit	leili	Yes No	
	uniting pouls d	Yes No	
Reduction of Preexisting disease v	- ·	Yes No	
Reduction of Named Ailments wa	illing perioa	☐ Yes ☐ No	

Unique Reference No: MHDI/Health/Retail/DoubleSuraksh/001 Double Suraksha UIN: MAGHLIP25035V012425



4. DETAILS	OF INSURED PERSONS TO BE COV	/ERED						
Details		Insured Person 1	Insured Person 2	Insured Person 3	Insured Person 4	Insured Person 5	Insured Person 6	Insured Person 7
Title								
Name*	(First Name)							
	(Middle Name)							
	(Last Name)							
Gender (M	ale/Female/None of these)							
Height* (cr	n)							
Weight* (kg	g)							
Eye Refract	ive Error Index (Left and Right Eye)							
Date of Bir	th* (DD MM YYYY)							
Relationshi	p with Proposer*							
Occupation (Salaried/S	n elf-employed/Professional/Others)							
ABHA No.								
	onate Benefit Sum Insured cted from Rs. 10L / 20L and 25L)#							
-# All I		Alexander and the same	- Carolina and					

# All Insured would have the same Sum Insured if the optional benefit selected 5. NOMINATION Policyholder is the nominee for all Insured members. Below details are for nominee to Policyholder. Name of Nominee	(To be Selected from Rs. 10L /	20L and 25L)#					
Policyholder is the nominee for all Insured members. Below details are for nominee to Policyholder. Name of Nominee First Middle Last Relationship with Proposer Date of Birth D M M Y Y Y Contact Number of Nominee If the Nominee is minor, Name and Address of Appointee and Relationship with Minor: Appointee Name Relationship with Nominee Contact Number of Appointee 6. EXISTING/PREVIOUS INSURANCE DETAILS Is the proposer or the persons proposed, already insured under or proposed for a health insurance policy with Magma HDI General Insurance Company Limited or any other insurance company? Yes No If YES, please indicate below the Policy/Application number(s) (Please mention application number in case of pending proposal.) Since when are you continuously insured?: D M M Y Y Y Insured Person Name (First, Middle, Last) Insurer Name Policy No./ Period of Insurance Sum Insured (₹) Claims details, if any	# All Insured would have the sar	ne Sum Insured if the op	tional benefit selected				
Name of Nominee First Middle Last Relationship with Proposer Date of Birth D M M Y Y Y Contact Number of Nominee If the Nominee is minor, Name and Address of Appointee and Relationship with Minor: Appointee Name Relationship with Nominee Contact Number of Appointee 6. EXISTING/PREVIOUS INSURANCE DETAILS Is the proposer or the persons proposed, already insured under or proposed for a health insurance policy with Magma HDI General Insurance Company Limited or any other insurance company?	5. NOMINATION						
Relationship with Proposer Contact Number of Nominee If the Nominee is minor, Name and Address of Appointee and Relationship with Minor: Appointee Name Relationship with Nominee Contact Number of Appointee 6. EXISTING/PREVIOUS INSURANCE DETAILS Is the proposer or the persons proposed, already insured under or proposed for a health insurance policy with Magma HDI General Insurance Company Limited or any other insurance company? ☐ Yes ☐ No If YES, please indicate below the Policy/Application number(s) (Please mention application number in case of pending proposal.) Since when are you continuously insured?: ☐ ☐ M M Y Y Y Y Insured Person Name (First, Middle, Last) Insurer Name Policy No./ Application No. From To Sum Insured (₹) Claims details, if any	Policyholder is the nominee for	all Insured members. Be	elow details are for nomi	nee to Policyholder.			
Contact Number of Nominee If the Nominee is minor, Name and Address of Appointee and Relationship with Minor: Appointee Name Relationship with Nominee Contact Number of Appointee 6. EXISTING/PREVIOUS INSURANCE DETAILS Is the proposer or the persons proposed, already insured under or proposed for a health insurance policy with Magma HDI General Insurance Company Limited or any other insurance company? □ Yes □ No If YES, please indicate below the Policy/Application number(s) (Please mention application number in case of pending proposal.) Since when are you continuously insured?: □ □ M M Y Y Y Y Insured Person Name (First, Middle, Last) Insurer Name Policy No./ Application No. From To Sum Insured (₹) Claims details, if any	Name of Nominee	First		Middle		Last	
If the Nominee is minor, Name and Address of Appointee and Relationship with Minor: Appointee Name Relationship with Nominee Contact Number of Appointee 6. EXISTING/PREVIOUS INSURANCE DETAILS Is the proposer or the persons proposed, already insured under or proposed for a health insurance policy with Magma HDI General Insurance Company Limited or any other insurance company? ☐ Yes ☐ No If YES, please indicate below the Policy/Application number(s) (Please mention application number in case of pending proposal.) Since when are you continuously insured?: ☐ ☐ M M Y Y Y Y Insured Person Name (First, Middle, Last) Insurer Name Policy No./ Application No. From To Sum Insured (₹) Claims details, if any	Relationship with Proposer			Date of Birth	DDMMYYYY		
Appointee Name Relationship with Nominee Contact Number of Appointee 6. EXISTING/PREVIOUS INSURANCE DETAILS Is the proposer or the persons proposed, already insured under or proposed for a health insurance policy with Magma HDI General Insurance Company Limited or any other insurance company? ☐ Yes ☐ No If YES, please indicate below the Policy/Application number(s) (Please mention application number in case of pending proposal.) Since when are you continuously insured?: ☐ ☐ M M Y Y Y Y Insured Person Name (First, Middle, Last) Insurer Name Policy No./ Period of Insurance Sum Insured (₹) Claims details, if any	Contact Number of Nominee						
6. EXISTING/PREVIOUS INSURANCE DETAILS Is the proposer or the persons proposed, already insured under or proposed for a health insurance policy with Magma HDI General Insurance Company Limited or any other insurance company? ☐ Yes ☐ No If YES, please indicate below the Policy/Application number(s) (Please mention application number in case of pending proposal.) Since when are you continuously insured?: ☐ ☐ MM Y Y Y Y Insured Person Name (First, Middle, Last) Insurer Name Policy No./ Period of Insurance Sum Insured (₹) Claims details, if any	If the Nominee is minor, Name	and Address of Appoin	tee and Relationship with	Minor:			
Is the proposer or the persons proposed, already insured under or proposed for a health insurance policy with Magma HDI General Insurance Company Limited or any other insurance company? ☐ Yes ☐ No If YES, please indicate below the Policy/Application number(s) (Please mention application number in case of pending proposal.) Since when are you continuously insured?: ☐ ☐ M M Y Y Y Y Insured Person Name (First, Middle, Last) Insurer Name Policy No./ Application No. From To Sum Insured (₹) Claims details, if any	Appointee N	Name	Relations	ship with Nominee		Contact Number of	Appointee
Is the proposer or the persons proposed, already insured under or proposed for a health insurance policy with Magma HDI General Insurance Company Limited or any other insurance company? ☐ Yes ☐ No If YES, please indicate below the Policy/Application number(s) (Please mention application number in case of pending proposal.) Since when are you continuously insured?: ☐ ☐ M M Y Y Y Y Insured Person Name (First, Middle, Last) Insurer Name Policy No./ Application No. Period of Insurance From To Sum Insured (₹) Claims details, if any							
Is the proposer or the persons proposed, already insured under or proposed for a health insurance policy with Magma HDI General Insurance Company Limited or any other insurance company? ☐ Yes ☐ No If YES, please indicate below the Policy/Application number(s) (Please mention application number in case of pending proposal.) Since when are you continuously insured?: ☐ ☐ M M Y Y Y Y Insured Person Name (First, Middle, Last)	(= \(\sigma = \sigma \)	D					
insurance company? ☐ Yes ☐ No If YES, please indicate below the Policy/Application number(s) (Please mention application number in case of pending proposal.) Since when are you continuously insured?: ☐ ☐ M M Y Y Y Y Insured Person Name (First, Middle, Last) Insurer Name Policy No./ Application No. From To Sum Insured (₹) Claims details, if any							
Since when are you continuously insured ?: □□□MMYYYYY Insured Person Name (First, Middle, Last) Insurer Name Policy No./ Application No. From To Sum Insured (₹) Claims details, if any			under or proposed for a l	nealth insurance policy v	vith Magma HDI Gener	al Insurance Compan	y Limited or any other
Since when are you continuously insured ?: □□□MMYYYYY Insured Person Name (First, Middle, Last) Insurer Name Policy No./ Application No. From To Sum Insured (₹) Claims details, if any	If YES, please indicate below the	Policy/Application numb	per(s) (Please mention app	lication number in case	of pending proposal.)		
(First, Middle, Last) Insurer Name Application No. From To Sum Insured (₹) Claims details, if any	• •	, , , ,	. , ,		3 p. 1, 1, 1, 1, 1, 1, 1, 1, 1, 1, 1, 1, 1,		
(First, Middle, Last) Application No. From To	Insured Person Name	1 1	Policy No./	Period o	of Insurance	C 1 1(3)	Cl : 1 : 1 : 1
DD/MM/YYYY DD/MM/YYYY	(First, Middle, Last)	Insurer Name	Application No.	From	То	Sum Insured (₹)	Claims defails, if any
				DD/MM/YYYY	DD/MM/YYYY		
	existing policy in addition to the inf	formation given above					

7. MEDICAL AND LIFESTYLE INFORMATIO	N*							
SECTION A: Have any of the person proposed to be insured ever suffered from / are suffering from any of the following: Please tick 'YES" for insured person wherever applicable and provide details in Section B	Yes / No	Insured Person 1	Insured Person 2	Insured Person 3	Insured Person 4	Insured Person 5	Insured Person 6	Insured Person 7
Hypertension History								
a) Duration								
b) Medication								
c) Dosage								
2. Diabetes Mellitus History								
a) Type 1 or Type 2								
b) Duration								
c) Medication								
d) Dosage								

		Yes / No	Insured Person No.
3.	Heart and Circulatory Conditions/Disorders: chest pain, angina, high cholesterol/lipids, palpitations, congestive heart failure, coronary artery disease, heart attack, bypass surgery/angioplasty, valve disorder/replacement, pacemaker insertion, rheumatic fever, congenital heart condition, varicose veins, thrombosis, blood disorders etc.?	ΥN	1 2 3 4 5 6 7
4.	Urinary Conditions/Disorders: Blood in urine, urinary frequency, painful/difficult urination Kidney and/or Bladder infections, stones of urinary system, renal failure, dialysis or Any Other Kidney/Urinary Tract Or Prostate Disease	ΥN	1 2 3 4 5 6 7
5.	Musculoskeletal Conditions/Disorders: Joint/back pain Arthritis, Spondylosis, Joint Replacement Or Any Other Disorder of Muscle/Bone/Joint/ligaments, tendons or discs, gout, herniated disc, amputation/prosthesis	ΥN	1 2 3 4 5 6 7
6.	Respiratory Conditions/Disorders: Shortness/difficulty of breath, Tuberculosis, Asthma, Bronchitis, Chronic Obstructive Pulmonary Disease COPD, chronic cough , coughing of blood, etc or any Other Lung / Respiratory Disease	ΥN	1 2 3 4 5 6 7
7.	Digestive Conditions/Disorders: Jaundice, chronic diarrhea, intestinal bleeding/problems/polyps, diseases of the pancreas, liver or gall bladder, hepatitis A/B/C/other, jaundice, Cirrhosis, unexplained weight loss or gain, eating disorder or any Other Gastro Intestinal condition	ΥN	1 2 3 4 5 6 7
8.	Cancer/Tumor - Benign Or Malignant tumor, Any Growth/Cyst, any Cancer	YN	1234567
9.	Brain/Nervous System/ Psychiatric Conditions/Disorders: Loss of consciousness, fainting, dizziness, numbness/tingling, weakness, paralysis, head injury, stroke, migraine headaches or chronic severe headaches, sleep apnea, multiple sclerosis, seizures/epilepsy or any Other Brain/ Nervous System Disease, Mental/Psychiatric disorder	YN	1 2 3 4 5 6 7

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	Yes / No	Insured Person No.
 Female Reproductive Conditions/Disorders: Pelvic pain, abnormal, menstrual bleeding abnormal PAP smear, endometriosis, Fibroid, Cyst/Fibroadenoma, Bleeding Disorder, Pelvic infection Or Any Other Gynecological / Breast cysts/lumps/tumor 	YN	1 2 3 4 5 6 7
11. Is any female person proposed to be insured pregnant, tested positive with a home pregnancy test, or in the process of adoption or becoming a surrogate?	ΥN	1 2 3 4 5 6 7
12. Metabolic and Endocrine Conditions/Disorders: Adrenal/pituitary disorders, lupus, scleroderma, thyroid disorders, any autoimmune/genetic disorder	YN	1 2 3 4 5 6 7
13. Does the person proposed to be insured suffer from any chronic or long-term medical condition, or have any other disability, abnormality or recurrent illness or injury or unable to perform normal activities?	ΥN	1 2 3 4 5 6 7
14. Does the person proposed to be insured use tobacco products/cigarettes or drinks alcohol?	YN	1234567
15. Does any of the person proposed to be insured suffers from any infertility related condition?	YN	1234567
16. Has any person proposed to be insured consulted with or received treatment from any doctor or other health care provider for any other condition or symptom(s)/any psychiatric condition/undergone any hospitalization/illness/surgery/ currently taking medication(s) for any condition or medical procedures (including diagnostic testing)	YN	1234567
17. Have you or any of the persons proposed to be insured been diagnosed with or undergone surgery for any of the following Critical Illnesses, prior to proposing for this cover - Cancer, Heart Attack, Coronory Artery, Bypass Graft, Heart Valve Replacement/ Repair, Coma, Kidney Failure, Stroke, any Transplant, Paralysis, Multiple Sclerosis, Motor Neurone Disease or HIV/AIDS	ΥN	1234567
For Accidental Death/PTD Cover		
18. Has any of the applicants suffered or currently suffering from seizure disorder or any physical or mental defects/ impairment/ infirmity/deformity or any condition that may effect mobility/ sight/hearing/speech?		
19. Does the applicant's occupation require him/her to engage in hazardous activities or handling hazardous material or working at heights, as cabin crew, in sea/river faring vessels, with high voltage, or be a part of armed forces?		

SECTION B: Name and details of Illness / Medicine / Test / Surgery / Diopter grade (for questions answered as yes in SECTION A above)	Date of Last Consultation	Doctor's Name	Hospital Name & Phone No.	Ailment Details
Insured Person 1:				
Insured Person 2:				
Insured Person 3:				
Insured Person 4:				
Insured Person 5:				
Insured Person 6:				
Insured Person 7:				

Any other details:

Please add additional sheets if required.

Section C: Important Notes:

- 1. The information that you give to Us on this proposal form or in any supplementary information form or documentation supplied by you or on your behalf will influence Our decision to offer insurance and the terms upon which to offer it. Further, any policy We issue will be based on what you have communicated to Us. It is therefore important that your answers are complete and accurate in all respect.
- 2. The questions in this proposal are indicative rather than exhaustive. You must provide Us with all information relevant to the risk to be insured, even if it is not the subject of a question in this proposal. If you are in any doubt as to what information should be given, you should liaise with your insurance advisor/company.
- 3. Acceptance of your proposal would be subject to receipt of complete medical reports (wherever applicable), medical underwriting and realization of full premium amount by the company and the insurance coverage will commence from the date of underwriting by the company.
- 4. The list of exclusions/inclusions and other policy details are indicative, for complete list and comprehensive details kindly refer policy wordings.

Castian	η.	Emmailer	Physician	ما منسنام،

Section D: Family Physician details:			
Name:		Contact No.:	
8. PAYMENT DETAILS			
1. Payment Details: Please tick (🗸) payme	nt option Premium Amount (₹)	Cash Cheque/NEFT/DD Payment Option Di	gital Payment
Cheque/NEFT/DD Number		Pate DDMMYYYY Bank	
	direct bank transfer, please provide the follo	wing details: (please enclose a cancelled cheque along with the proposal fo	orm)
Name of the bank	Branch	City	
Account Type	IFSC Code	Account Number	
Electronic Clearing Service (Debit Cl Proposal No.	•		
Proposal No. To, Magma-HDI General Insurance Company Ref: Authorization of customer to remit func	Ltd., Development House, 24 Park Street, K	olkata – 700 016	
Customer Information:	is/payments to < bank Name / miloogh Lie	chomic cleaning service	
a) Account Holder(s) Name (As appearing	g in the Bank Records		
b) Bank Name	c) Bo	nk Branch Name	
d) Address	e) Br	anch City	
f) Account Type	g) Ac	count No.	
h) Ledger No./Ledger Folio No.	i) 9	Digit MICR Code	

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Declaration

(Please refer to sales brochure for approximate premium details due to change in age applicable at the time of renewal)

I, hereby declare that the particulars given are correct and complete. I understand and accept that the transaction will be effected on the due date as opted by me in this form subject to the payment of premium on the policy (provided the day is a working day). If the transaction is delayed or not effective at all for reasons of incomplete or incorrect information, I/we would not hold the user institution responsible. I/We have read all the terms and conditions as are applicable for availing of this ECS Debit service from/through the user institution and agree to discharge the responsibility expected of me/us as a participant under the scheme.

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Date: DDMMYYYY

Double Suraksha UIN: MAGHLIP25035V012425



4.	Intermediary Declaration
	[Full Name] in my capacity as an Insurance Advisor/Specified Person of the Corporate Agent/Authorized employee of the Broker/Relationship Officer, do hereby declare that I have explained all the contents of this Proposal Form, including the nature of the questions contained in this Proposal Form to the proposer including statement (s), information and responses(s) submitted by him/her in this Proposal Form to questions contained herein or any details sought herein will form the basis of the Contract of Insurance between the Company and the Proposer, if this Proposal Form to questions company for issuance of the Policy. I have further explained that if any untrue statement(s)/information/response(s) is/are contained in this Proposal Form / including addendum(s), affidavits, statements, submissions, furnished/ to be furnished, or if there has been a non-disclosure of any material fact, the Policy issued to his/her favour pursuant to this Proposal may be treated by the Company as null and void and all premium paid under the Policy may be forfeited to the Company.
	License No./ID (Advisor/Corporate Agent/Broker/Relationship Officer) Date: DDDMMYYYYYY Signature of the Insurance Advisor:
	I [name of proposer] confirm that I have understood all the features/benefits available under this Policy.
	Signature of the Proposer:
	Date: DDMMYYYYY
5.	Proposer Declaration (Certification where for any reason, the proposal and other connected papers are not filled in by the Proposer). The contents of the proposal form and connected documents have been fully explained to me and I have fully understood the significance of the proposal contract. The Proposal Form is filled by under my instruction and I found it to be correct.
	Date: DDMMYYYYYY Signature of the Proposer:
	AML Guidelines I/we hereby confirm that all premiums paid / payable in future will be from bonafide sources and not paid out of proceeds of crime and that such premiums are not disproportionate to my/our income. I / we understand that the Company has the right to call for documents to establish sources of funds and to cancel the insurance policy in case I / we are found guilty by any competent court of law under any of the statutes, directly or indirectly governing the prevention of money laundering law in India. Date: DDMMYYYYYY Signature of the Proposer:
	Are you or any of the proposal applicant are PEPs* or a close relative of PEPs*? Yes No If yes, please share the details "Politically Exposed Persons" (PEPs): *(PEPs) are individuals who are or have been entrusted with prominent public functions in a foreign country, e.g., Heads of States/Governments, senior politicians, senior government/judicial/military officers, senior executives of state-owned corporations, important political party officials, etc.
2.	Additional Information: Nationality: Indian Non-Indian If, Non-Indian, please specify Country:
3.	Type of Organisation: (i) Corporations (ii) Trust (iii) Government (iv) Partnership (v) Non-Government Organisations (vi) Co-operatives (vii) Society (viii) Private Limited Company (ix) Public Limited Company (x) others, please specify
4.	Source of Funds: Business: Others (please specify)
•	11. GENERAL INFORMATION
1.	Caution You are obliged to make a full and frank disclosure of all facts material to the assumption of risk in relation to you and every person proposed to be insured that would influence Our decision to issue the policy or the terms on which it is issued, and you must not misrepresent any information to Us. The obligation continues until the policy is issued and does not end with the submission of this proposal form. If, therefore, there is any change in the information given herein or new information comes to light before the policy is issued, then you must inform Us of the same in writing without delay. If there is insufficient space to provide additional information, whether as requested or otherwise, then please attach an extra sheet duly signed. If the disclosure obligations are breached then such breach may render any policy issued void.
Pro	ohibition of Rebates Under Section 41 of Insurance Law (Amendment) Act, 2015
	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 continuing the policy accept any rebate except such rebate as may be allowed in accordance with the published prospectus or tables of the Insurer. If any person fails to comply with sub-regulation (1) above, he shall be liable to payment of a fine which may extend to Ten Lakh Rupees.
_	Acknowledgment
Pro We Rs.	posal No Date: D D M M Y Y Y Y Y e acknowledge with thanks the receipt of your proposal and amount by Cash/Cheque/NEFT/Demand Draft/ Others of amount of dated dated dated
be pre	wither the submission to Us of a completed proposal for Insurance nor any payment for any policy sought obliges Us to agree to issue a policy, which decision is and always shall in Our sole and absolute discretion. If We accept a proposal for Insurance, it shall be subject to the policy terms and conditions, and We shall have no liability whatsoever if armium is not received by Us in full and in time or is not realized. If We do not accept the proposal, we will inform you and refund the payment, if any, received from you without erest.
Sig	nature of the receiver and office seal

Magma HDI General Insurance Co. Ltd. | www.magmahdi.com | E-mail: customercare@magma-hdi.co.in | Toll-free no.: 1800 2663202 | Registered Office: Development House, 24 Park Street, Kolkata – 700016. CIN: U66000WB2009PLC136327 | IRDAI Reg. No. 149 | Trade Logo displayed above belongs to Magma Ventures Private Limited and HDI Global SE, and is used by Magma HDI General Insurance Company Limited, under license. Version No.: PEDS.ver24.07.24.