RAHEJA QBE
Raheja QBE General Insurance Company Limited
5th Floor, A Wing, Fulcrum, IA Project Road, Sahar, Andheri East, Mumbai – 400059, India.
Tel: 022-69155050 I Email: customercare@rahejaqbe.com I Website: www.rahejaqbe.com
CIN: U66030MH2007PLC173129, IRDAI Reg. No. 141

PROPOSAL FORM (URN- RQBESU2024-25)

RQBE Surrogacy and Oocyte Donor Insurance Policy

(For Office Use Only)		Sr. No.	
Intermediary Name		Intermediary Code	

PROPOSER DETAILS:

Proposer Type	☐ Intending Couple		☐ Intending Woman
Name	Male:	Female:	
Please mention the Name of the Proposer			Intending women will be considered as proposer by default
Date of Birth	DD/MM/YYYY	DD/MM/YYYY	DD/MM/YYYY
Age			
Occupation	☐ Salaried ☐ Self-Employed ☐ Others, Pls specify	☐ Salaried ☐ Self-Employed ☐ Others, Pls specify	☐ Salaried ☐ Self-Employed ☐ Others, Pls specify
*ID Proof	☐ PAN _____ ☐ Passport_____ ☐ DL No._____ Any Other ID with No.	☐ PAN ☐ Passport ☐ DL No. Any Other ID with No.	☐ PAN _____ ☐ Passport_____ ☐ DL No._____ Any Other ID with No.
Nationality#	☑ Resident Indian	☑ Resident Indian	☑ Resident Indian
Marital Status			☐ Widow ☐ Divorcee
*Mobile No.	+91	+91	+91
Tel (R)			
#Policy can be proposed and purchased by Indian Nationals only			

OTHER DETAILS OF THE PROPOSER:

E Repository Name:		E Insurance Account No. (if available)	
GSTIN		*Email ID	
Door / Flat No		Building No / Name	
Street Name		Landmark	
Sub Area / Village		Area / Tehsil	
City	District	PIN	State
*Mandatory fields			

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INFORMATION OF THE PERSONS TO BE INSURED

Type of Insured person (pls tick as applicable)			☐ **Surrogate Mother**			☐ **Oocyte Donor**		
Name of the Personsto be Insured	Date of Birth	Height in Cms	Weight in Kgs	Marital Status	Occupation	No of live children (in case of surrogate mother)	Nationality	ABHA Number (14 digits)#
	DD/MM/YYYY							
	DD/MM/YYYY							

#Ayushman Bharat Health Account

In case any insured person(s) wish to generate his/her ABHA ID. Kindly visit the link: https://healthid.ndhm.gov.in/register

COVERAGE DETAILS:

Policy Type: ☐ Individual	Policy Tenure (please tick): ☐ 3 years for Surrogate Mother ☐ 1 year for Oocyte Donor
Sum Insured (in Rs.) (Please Tick)	☐ 3 lakhs ☐ 5 lakhs ☐ 7.5 lakhs ☐ 10 lakhs
Coverage required from am/pm of	DD/MM/YYYY to midnight of DD/MM/YYYY

NOMINATION

(Nominee details are mandatory. We do not get any separate nomination form signed. In case the nominee is a minor, the guardian details will have to be provided)

Nominee Name	Nominee Relationship with the Insured
Nominee Contact Details	
Nominee mentioned above is for the proposer. For other members covered under the policy, proposer is deemed to be thenominee.	

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SUPPORTING MANDATORY DOCUMENTS TO BE SUBMITTED WITH THE PROPOSAL FORM BY THE PROPOSER & INSURED

INTENDING COUPLE / WOMAN	□ 1. Certificate of recommendation from the National Assisted Reproductive Technology and Surrogacy Board
	□ 2. Certificate of essentiality issued by the appropriate authority constituted as per section 35 of The Surrogacy (Regulation) Act, 2021
	□ 3. Certificate of a medical indication in favor of either or both members of the intending couple or indenting woman necessitating gestational surrogacy from a District Medical Board
	□ 4. Eligibility certificate issued in favor of the Intending couple or woman by the appropriate authority, constituted as per section 35 of The Surrogacy (Regulation) Act, 2021
SURROGATE MOTHER	□ 1. Eligibility certificate issued in favor of the Surrogate Mother by the appropriate authority, constituted as per section 35 of The Surrogacy (Regulation) Act, 2021
	□ 2. Certificate of medical and psychological fitness of the Surrogate Mother for surrogacy and surrogacy procedures from a registered medical practitioner
OOCYTE DONOR	□ Form 13 – Consent form for the Donor of Oocytes as prescribed in The Assisted Reproductive Technology (Regulation) Rules, 2022

PREVIOUS / EXISTING HEALTH INSURANCE DETAILS

Do any of the proposed members have any existing Health Insurance Cover? If Yes, provide following details								
Name of the Persons to be Insured	Insurance Company	Details of Coverage Source	Expiring Policy No.	Date of Commencement of cover*	Policy Expiry Date*	Sum Insured Rs.	Claim details	Claim free Bonus (if applicable)* in Rs
Date of commencement of cover for first time, please enter start date of your existing/previous health Insurance Policy * Please attach previous policy copies and renewal notices as proof for the initial commencement date								

PREMIUM PAYMENT DETAILS

PREMIUM PAYMENT MODE: Single payment Mode		
Signature / Thumb Impression of Proposer	Date: DD/MM/YYYY	Place:
(For Office Use Only)		
Premium Payable for the policy tenure (excluding GST) Rs.		
GST Rs.		
Premium (including of GST) Rs.		
Cheque*/ Draft*/PO* Number	Date: DD/MM/YYYY	
Transaction Reference No. for Online Transfer	Transaction Date	
Amount (Rs.)	Amount (in words)	
Bank Name	Bank Branch	

UIN: RQBHLIP25035V012425

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DECLARATION OF THE SURROGATE MOTHER

i. I certify that I have not born any child through Surrogacy before the commencement of this policy ii. I have been tested for HIV, Hepatitis B, and Hepatitis C and shown to be seronegative for these viruses before embryo transfer. iii. I have not provided my own gametes for the purpose of surrogacy iv. I have not act as a surrogate mother more than once in lifetime		
Signature / Thumb Impression of Proposer	Date: DD/MM/YYYY	Place:

DECLARATION OF THE OOCYTE DONOR

i. I have donated oocytes only once in lifetime ii. I am free from any of infectious disease or genetic disorder		
Signature / Thumb Impression of Proposer	Date: DD/MM/YYYY	Place:

DECLARATION OF THE INTENDING COUPLE / WOMAN

i. I/We certify that the Surrogacy procedure / Oocyte Retrieval procedure will be carried out in Registered Surrogacy Clinic / Assisted Reproductive Technology Bank/Clinic in compliance with THE SURROGACY (REGULATION) ACT, 2021 and THE ASSISTED REPRODUCTIVE TECHNOLOGY (REGULATION) ACT, 2021 respectively. ii. I/We shall not have the service of more than one surrogate at any given time iii. I/We shall not have simultaneous transfer of embryos in the woman and in a surrogate.		
Signature / Thumb Impression of Proposer	Date: DD/MM/YYYY	Place:

DECLARATION BY THE PROPOSER

i. I/We hereby declare on my behalf and on behalf of all persons proposed to be insured that the above statements are true and complete in all respects to the best of my knowledge and that I/We am/are authorized to propose on behalf of these other persons.

ii. I understand that the information provided by me will form the basis of insurance policy, is subject to the Board approved under writing policy of the Insurance company and that the policy will come into force only after full receipt to the premium chargeable.

iii. I/We further declare that I/We 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.

iv. I/We declare and further consent to the company. Seeking medical information from any hospital who at any time has attended on the life to be insured/proposer or from any past or present employer concerning anything which affects the physical and mental health of the life to be assured/proposer and seeking information from any insurance company to which an application or insurance on the life to be assured/proposer has been made for the purpose of underwriting the proposal and /or claim settlement.

v. I/We authorize the company to share information pertaining to my proposal including the medical records for the sole purpose of proposal underwriting and/ or claims settlement and with any Governmental and/or Regulatory Authority.

vi. I/We aware of premium loading, (if any declared above) for habit's & diseases as declared / mention by me/ us above.

vii. I/ We hereby agree to keep record of KYC details of all the individual members covered under the group

insurance and ensure to provide the details of beneficiaries to the Company as and when required.

viii. I/We provide my/our consent to access my/our (all insured) medical and personal records/details, as are available in my/ our Ayushman Bharat Health Account (ABHA) and share the same with Third Party Administrators, Reinsurer (if applicable), Service Provider/s of Raheja QBE General Insurance Company Limited and/or with any Governmental and/or Regulatory authority for the sole purposes of underwriting my/ our proposal and/ or for checking the authenticity of claims lodged by me/ us and/ or to comply with the applicable Law/Regulations.

Signature / Thumb Impression of Proposer	Date: DD/MM/YYYY	Place:
The Insurance Agent/Intermediary has explained Product Features and Suitability clearly and, in the language, understandable to me. □ Yes □ No		
Signature /Thumb Impression of Proposer Date: DD/MM/YYYY	Signature of the Insurance Agent/Intermediary Date: DD/MM/YYYY	

Declaration for compliance with anti-money laundering regulations

I, _____ (Full Name) hereby declare that the source of funds for premium paid for obtaining this insurance cover is through legitimate funds from our Bank Account no. with _ (name of bank) (Bank Branch & IFSC code) I/We hereby give my/our consent to Raheja QBE General Insurance Company Limited ('the Company') to verify and obtain my/our identity/address proof as well as the identity /address proof of the insured through Central KYC Registry or UIDAI or through any other modes for the purpose of undertaking KYC.

Place:

Date: DD/MM/YYYY Signature /Thumb Impression of Proposer

STATUTORY WARNING

Section 41 of Insurance Act, 1938 – Prohibition of Rebates:

(1) No person shall allow or offer to allow, either directly or indirectly, as an inducement to any person to take 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

(2) Any person making default in complying with the provisions of this section shall be punishable with fine, which may extend to Rupees Ten Lakhs.

INTERMEDIARY DECLARATION

I, (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 response(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 is accepted by the 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, the Company shall have the right to vary the benefits which may be payable and further more if there has been a non-disclosure of any material fact, the policy issued to his/her favor pursuant to this Proposal may be treated by the Company as null and void and all premiums paid under the Policy may be forfeited to the company.

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Date: Signature of Agent

Place: License No.

VERNACULAR DECLARATION

** Applicable where the Proposer is illiterate or is suffering from a disability due to which writing is restricted or where the Proposer has signed in vernacular language.

(Note: The below must be witnessed by someone other than the Advisor/Employee of the Company).

I/We certify that the product applied for by me/us and the contents of the Proposal Form have been clearly explained to me/us and I/we have fully understood them. I/We further certify that the replies in the Proposal Form have been recorded as per the information provided by me/us. I, (Full name of the witness)_____ _____ (Relation with the Proposer/Primary insured) _____ adult and inhabitant of (city) and residing at do hereby certify that I have read out and explained the contents of the Proposal Form and all other documents incidental to availing the insurance policy from Raheja QBE General Insurance Company Limited, to the Proposer/Primary Insured and he/she/they have understood the same. I/we declare that whatever I/we have stated hereinabove is true and correct to the best of knowledge and belief.

Date: DD/MM/YYYY

Place: Signature of the Witness Signature/Thumb impression of the Proposer/Primary Insured

UIN: RQBHLIP25035V012425