(LI-24)

Affix Combined Photograph of Parents and Child

DEPARTMENT OF POSTS
PROPOSAL FORM FOR POSTAL LIFE INSURANCE
(Children Policy)

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 LI-7(a)

Amount deposited ₹

Post Office at which deposited

ACG- 67 Receipt No and Date

Policy No.

All entries should be filled in capital letters:

1. Parent's Policy number

2. Parent's Name

3. Father's Name

4. Name of the child

5. Category (Department/ Organisations)

6. PH Code

7. Sex M F

8. Address Details for Correspondence

Pin code

Permanent Address

Pin code

9. Employment Details of Parents

Designation

Address

Pin code

10. (a) Doctor's Code

(b) Doctor's Name

11. Date of Birth of Child

12. Date of Proposal

13 .Date of Declaration

14. Date of Acceptance

M

15. Payment Type

16. Medical | Y | N |

17. Type of Policy

18. Age at Maturity

19. Sum Assured ₹

20. Premium Amount ₹

21. Mode of Payment | C | P |

22. PAN No.

23. Mobile No.

24. E-mail ID

25. Postal A/c Office

PAO code

PAO Sub code

Address

26.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)**

27.If policy is being funded by HUF, give particulars of HUF.

28.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

29.Nature of proof given in support of date of birth of parent and child …….
……..

30.If premia is to be paid in cash, state Name of Post Office at which you wish to pay
(Name of Post Office)…….....

31. Has any of your relatives living or dead suffered from any hereditary or infectious diseases like Insanity/ Epilepsy/ Gout/ Tuberculosis/ Leprosy/ Diabetes/ HIV+ AIDS?
If so, give details……
……..

(Family includes mother, father, brothers and sisters.)

32. **Personal History:**

(a) Are you and your child in sound health?.....

(b) Have you and your Child ever suffered from any of the following:

(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
(viii) Diabetes	:	Yes	No
(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

Signature of parent

33. <u>MEDICAL EXAMINER'S CERTIFICATE</u>

Certified that I have carefully examined Shri/Smt. _____ the proponent whose signature is given below today the _____Day of _____2001.

On careful examination of the proponent and after going through the information furnished by him/ her under column 33, I find the proponent to be medically fit. He / She does not suffer from any terminal or other serious health hazard which would be risk to his/her life. I recommend acceptance of his/her proposal of Postal Life Insurance policy.

OR

The proponent is medically unfit. I do not recommend acceptance of his/her proposal for Postal Life Insurance policy.

Signature of Proponent

Signature of Medical Examiner:

Name :

Code :

Seal :

Date :

NOTE FOR MEDICAL OFFICER

a) When there are two or more cases of diabetes in the family, report of Glucose" Tolerance Test and Urine would be required and if the proponent is overweight in addition to the family history of diabetes or there is a suspicion of sugar in the urine or personal history of glycosuria, a blood sugar report would be necessary.

b) If the proponent is overweight or has doubtful family history, an electrocardiogram and a report on the scanning of the chest would be required.

c) If the proponent is underweight and has family history of TB, an X-Ray of the chest would be required.

d) Expense of the above mentioned tests will have to be borne by the proponent.

34. **Declaration of DO/FO/Agent**

I _____Code No._____

certify that the information in the proposal form has been furnished by the proponent in my presence. All columns have been completed and are correct and no question is left un-answered. The proposal is recommended for acceptance.

Date……. Signature

Name_____

Designation_____

35.CERTIFICATE OF IMMEDIATE SUPERIOR

Certified that_____ is a permanent/temporary employee in _____ and information furnished against column No. 2,3,4,5,7,8,9 and 11 of this proposal form is correct and as per his/her service records.

Date Signature

Place Name
Designation/Seal

36.TO BE FILLLED IN BY DO/FO (PLI)/AGENT

Type_____ Sum Assured ₹_____

Age at entry_____ Premium rate ₹_____

Receipt(LI-7(a) No._____Date_____ Amount ₹_____

Post Office where payment is to be made_____

I _____Code No._____
certify that the information in the proposal form has been furnished by the proponent in my presence. All columns have been completed and are correct and no question is left un-answered. The proposal is recommended for acceptance.

DATE SIGNATURE

37. <u>CERTIFICATE OF DDM/ADM (PLI) /SR/SUPDT POS</u>

Certified that the entries against column No. 1 to 31 and 34 to 36 have been verified by me and found in order. The proposal is accepted.

The proposal is rejected due to the following reasons

1.
2.
3.

DATE PA/ SS

ADM/DDM/SUPDT POS