



IN UNIT LINKED INSURANCE PRODUCTS, THE INVESTMENT RISK IN THE INVESTMENT PORTFOLIO IS BORNE BY THE POLICYHOLDER
Note: Please read carefully all the instructions mentioned at the back before filling up this proposal form.

Attach Recent Photograph of the proposer / Secondary Life / Secondary Annuitant
Attach Recent Photograph of Life Insured / Primary Life / Primary Annuitant

Office use Sales Person/Corporate Partner Code Channel Urban
Sales Person/Corporate Partner Name Branch Rural
CKYC Type Account Type
CKYC Number
Type of Plan
Type of Cover
Existing Policy holder/applicant provide their details

Section I: Personal Details of Life/Primary Life to be Insured/Primary Annuitant
1. Name: F I R S T M I D D L E L A S T
2. Maiden Name: F I R S T M I D D L E L A S T
3. Father's Name: F I R S T M I D D L E L A S T
4. Mother's Name: F I R S T M I D D L E L A S T
5. Spouse Name: F I R S T M I D D L E L A S T
6. Date of Birth: D D M M Y Y Y Y
7. Country of Birth:
8. Gender: Male Female Transgender
9. Marital Status: Single Married Widowed Divorced
10. US Person: Yes No
11. Nationality: Indian Others
12. Residential Status: Resident Indian NRI PIO Foreign National
13. Are you a tax resident of any country other than India? Yes No
14. Source of Income:
15. Mobile: Alternate No.
16. Email ID:
17. Educational Qualification: Post Graduate & above Graduate Diploma 12th Pass 10th Pass Below 10th Illiterate others
18. PAN Number:
19. ABHA No. (Ayushman Bharat Health Account)
20. Are you an employee of Pramerica Life or any of its Partner? Yes No
21. Occupational Details: Service Business Self Employed Professional Retired Student Homemaker Agriculturist others
Table: Name of the Organization/Business, Address of the Organization/Business, Exact Nature of Duties, Designation, Annual Gross Income (in ₹)

Section II: Details of the Proposer (if life assured different from proposer)/ Secondary Life/Secondary Annuitant
1. Name: F I R S T M I D D L E L A S T
2. Maiden Name: F I R S T M I D D L E L A S T
3. Father's Name: F I R S T M I D D L E L A S T
4. Mother's Name: F I R S T M I D D L E L A S T
5. Spouse Name: F I R S T M I D D L E L A S T
6. Date of Birth: D D M M Y Y Y Y
7. Country of Birth:
8. Gender: Male Female Transgender
9. Marital Status: Single Married Widowed Divorced
10. US Person: Yes No
11. Nationality: Indian Others
12. Residential Status: Resident Indian NRI PIO Foreign National
13. Relationship with Life to be Insured: Spouse Father Mother Grand Father Grand Mother Others
14. Are you a tax resident of any country other than India? Yes No
15. Source of Income:
16. Mobile: Alternate No.
17. Email ID:
18. Educational Qualification: Post Graduate & above Graduate Diploma 12th Pass 10th Pass Below 10th Illiterate Others
19. PAN Number:
20. ABHA No. (Ayushman Bharat Health Account)
21. Occupational Details: Service Business Self Employed Professional Retired Student Homemaker Agriculturist others
Table: Name of the Organization/Business, Address of the Organization/Business, Exact Nature of Duties, Designation, Annual Gross Income (in ₹)

Section III: Address Details (if address of Life to be Insured is different from Proposer) Yes No
Address for Communication with Proposer Residence Office Permanent
Address: F L A T N O. B U I L D I N G / H O U S E R O A D N A M E
D I S T R I C T / T A L U K A City C I T Y
State Country Pincode
Landmark

Permanent Address of Proposer (if different from Communication address)

Address City

State Country Pincode

Landmark

Section IV: Proposer / Policy Owner Electronic Insurance Account (eIA)

1. Do you have an eIA Account? Yes No If yes, please quote eIA Number

2. Do you wish to open Electronic Insurance Account & convert your policies into electronic policies? Yes No

3. Select your preferred Insurance Repository to open Electronic Insurance Account NSDL IR CAMSRep Kary IR CIRL Others Write IR Name

Section V: Nominee Details* (To be filled only if Life Insured & Proposer are same)

1. Are there Multiple/Different Nominees? Yes No (if yes, please fill Annexure for Multiple Nominations)

2. Name:

3. Date of Birth: 4. Gender Male Female Transgender 5. Relationship with Insured

Section VI: Appointee Details* (If Nominee is less than 18 years, Appointee is mandatory, Appointee must be above 18 years of age)

1. Name:

2. Date of Birth: 3. Gender Male Female Transgender 4. Relationship with Nominee

Section VII: Mandatory Details of the proposer as per AML guidelines

1. Identity Proof Passport PAN Card Voter's Identity Card Others (Specify) ID No Expiry date

2. Address Proof Passport Driving License Bank Passbook Others (Specify) ID No Expiry date

3. Income Proof IT Return CA Certificate Audited P&L A/C Others (Specify) ID No Expiry date

Section VIII: Lifestyle Questions & Personal Details of the Proposed Insured (not to be filled for Annuity Product)

	Life Insured/Primary Life		Proposer/Secondary Life		Life Insured /		Proposer/	
	Yes	No	Yes	No	Primary Life	No	Yes	No
1. Height in cms <input type="text"/> or in Ft / Inches <input type="text"/>								
2. Weight in Kgs <input type="text"/>								
5. Have you in the past used or do you use any habit forming drugs or narcotics or received any drug abstinence treatment? If Yes, give details <input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Do you consume alcohol? If Yes, please specify consumption per week Beer (pints per week) <input type="text"/> Hard liquor (30 ml pegs per week) <input type="text"/> Wine (glasses per week) <input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Do you smoke or consume tobacco in any form e.g. (paan, tobacco, gutka, etc.)? If Yes, please specify per day consumption of Cigarettes/Cigar sticks <input type="text"/> Bidi sticks <input type="text"/> Gutka pouch <input type="text"/> Paan <input type="text"/> Tobacco pouch <input type="text"/> Others <input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Have you ever stopped smoking/tobacco consumption in any form? (If Yes, please specify) Duration since stopped <input type="text"/> Reason for discontinuation <input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Is your occupation associated with any specific hazard or do you take part in activities or hobbies that could be dangerous in any way? (e.g. Occupation: chemical factory, mines, explosives, radiation, corrosive chemicals etc & hobbies: aviation other than fare paying passenger, mountaineering, deep sea diving or any form of racing) if yes, please complete the relevant Occupation/Avocation Questionnaire	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Are you employed in the Armed, Para-Military or Police Forces? If yes, please provide below details and complete the armed forces questionnaire Category after last Medical Examination: <input type="text"/> Not to be filled by Defence Personnel Dept/Div: <input type="text"/> Date of Last Medical Examination: <input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Have you ever been or currently being investigated, charge sheeted, prosecuted or convicted or acquitted or having pending charges in respect of any criminal/civil offences in any court of law in India or abroad? (If Yes, give details.) <input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Are you currently or do you intend to travel outside of India for more than 1 month? (If Yes, please complete the Travel Questionnaire)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. Are you (Proposed Holder/Proposed Insured/Premium Payor) or your family member(s) /close associate(s) a Politically Exposed Person (PEP)*. (If yes, please fill PEP Questionnaire)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Section IX: Medical Details (not to be filled for Annuity Product)

1. Are any of your Parents or Siblings suffering or have suffered from Heart Disease, Diabetes, Stroke, Hypertension, Raised Cholesterol, Cancer, Multiple Sclerosis, Alzheimer, Parkinson or any hereditary disease before the age of 60? (If yes, please provide details in the section below)

Life Insured / Proposer/
Primary Life Secondary Life

Life Insured/Primary Life						Proposer/Secondary Life					
Relationship with Insured	Age	Current Status	Details of present health & full particulars of any major illness	Age at Onset	Cause of Death	Relationship with Insured	Age	Current Status	Details of present health & full particulars of any major illness	Age at Onset	Cause of Death
Parent 1						Parent 1					
Parent 2						Parent 2					
Sibling 1						Sibling 1					
Sibling 2						Sibling 2					

2. Have you ever had symptoms of, been treated for, been advised to receive treatment or have undergone any investigations for any of the below?

The following conditions are provided as an example only. You are requested to disclose all disorders, disease or other health conditions, which are, or might be relevant. If answer for any of the questions in this section is "yes", please provide all medical reports, if available

	Life Insured / Primary Life		Proposer/ Secondary Life	
	Yes	No	Yes	No
(a) High Blood Pressure, Chest Pain, Angina, shortness of Breath, Palpitation, Rheumatic Fever, Heart Murmur, Heart Attack or any other symptoms or disorder pertaining to the heart or Circulatory System?	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> Y	<input type="checkbox"/> N
(b) Epilepsy, Depression, Mental ailment, Stroke, Paralysis, Multiple Sclerosis or any other Nervous breakdown?	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> Y	<input type="checkbox"/> N
(c) Tuberculosis, Asthma, Bronchitis, Avian Flu, difficulty in regular breathing or any other Respiratory Disorder?	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> Y	<input type="checkbox"/> N
(d) Cancer, Tumour, Cyst, Leukemia, Growth, Lump or other Malignancy?	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> Y	<input type="checkbox"/> N
(e) Stomach, Gastrointestinal disorder, Kidney, Liver, Bladder Disorder, Reproductive, Urinary Disorder, Hepatitis, Cirrhosis?	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> Y	<input type="checkbox"/> N
(f) High Blood Sugar, Diabetes, Thyroid or any other Gland Related Disorders?	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> Y	<input type="checkbox"/> N
(g) Any Disorder related to Ear, Eye, Nose, Throat or Skin?	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> Y	<input type="checkbox"/> N
(h) Any Back, Arthritis, Limbs, Spine, Joint or Bone Disorders or any other physical deformity/defect?	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> Y	<input type="checkbox"/> N
(i) Do you have Anaemia or any other blood related disorders?	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> Y	<input type="checkbox"/> N
(j) Have you or your spouse ever received any medical advice, counselling or treatment in connection with HIV/AIDS or Hepatitis B/C or any Sexually Transmitted Disease?	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> Y	<input type="checkbox"/> N

* If nominee/appointee address is different from Proposer, please provide in separate sheet and attach.

^ Politically Exposed Person(PEP) are individuals who are or have been entrusted with prominent public functions, for example Heads/ Ministers of Central/ State Government, Senior Politicians, Senior Government/ Judicial/ Military Officers, Senior Executive of state owned corporations, important Political Party Officials and immediate family members of above persons (Spouse, Children, Parents, Siblings, In-laws)

(k) Are you currently suffering from any illness, impairment or taking any medication/pills/drugs?	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> Y	<input type="checkbox"/> N
(l) Has there been weight loss or weight gain (> =5 Kgs) in the past year?	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> Y	<input type="checkbox"/> N
(m) Have you undergone or been advised to undergo surgery of any kind or any major organ transplant?	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> Y	<input type="checkbox"/> N
(n) During the past five years				
(i) Have you ever sustained an illness lasting for more than 5 days except for fever, common cold or cough?	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> Y	<input type="checkbox"/> N
(ii) Have you undergone or advised to undergo or awaiting any medical investigations like ECG, X-Ray, CT Scan, MRI, Echo or blood tests or been admitted to a hospital for treatment or investigations?	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> Y	<input type="checkbox"/> N
(iii) Have you been abstained from work for more than a week?	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> Y	<input type="checkbox"/> N

3. To be answered by Female applicants only

(a) Are you currently pregnant? If Yes, duration of weeks _____	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> Y	<input type="checkbox"/> N
(b) Have you undergone an abortion / caesarian section, or had a miscarriage? If Yes, mention period elapsed since the last occasion <input type="checkbox"/> in last 3 months <input type="checkbox"/> 3 to 6 months <input type="checkbox"/> more than 6 months	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> Y	<input type="checkbox"/> N
(c) Have you suffered from or do you have any Gynaecological problems or Illness related to uterus/ovaries or breasts?	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> Y	<input type="checkbox"/> N

If answer to any of the questions 2(a-n) & 3(a-c) is Yes, Please give the following details

Life Insured/Primary Life				Proposer/Secondary Life			
Details of the Treating / Family Doctor	Nature of ailment / disease etc	Date of diagnosis	Fully recovered or still undergoing treatment	Details of the Treating / Family Doctor	Nature of ailment / disease etc	Date of diagnosis	Fully recovered or still undergoing treatment
Name				Name			
Address				Address			

Section X: Previous Policy Details (not to be filled for Annuity Product)

1. Has any application or proposal for Life/Health/Accident/Critical Illness/Mediclaim including renewal and reinstatement ever been declined, deferred, withdrawn or accepted at special rates or terms by PLIL or any other insurer in India or abroad? (If yes, give details)	<input type="checkbox"/> Y Yes <input type="checkbox"/> N No	<input type="checkbox"/> Y Yes <input type="checkbox"/> N No
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Life Insured/Primary Life				
Policy / Proposal No.	Company Name	Sum Assured	Decision (Std/With Extra/Postponed/Declined/Not completed)	Status (Inforced/Lapsed/Applied)
Proposer/Secondary Life				
Policy / Proposal No.	Company Name	Sum Assured	Decision (Std/With Extra/Postponed/Declined/Not completed)	Status (Inforced/Lapsed/Applied)

2. In case Life Insured is a student / housewife, please provide insurance details regarding parents / husband / siblings

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Section XI: Details of Product Applied for

1. Product & Rider Details

Payment Options Limited Pay Regular Pay Single Pay **Mode of Payment** (Not Applicable for Single Pay Plan) Annually Semi Annually Quarterly Monthly

Product Name/ Rider Name	Policy Term	Premium Payment Term	Deferment Period	Sum Assured/ Annuity Amount	Premium/Purchase Price	Option	Payout Option	Additional Benefit/ Income Period
Base Product								
Rider 1								
Rider 2								
Rider 3								
Rider 4								

In case of Pramerica Life WOP rider, the rider Life Insured will always be the Proposer under the Proposal form

Applicable only for Term Insurance Plans

Optional Covers:

- Spouse Cover, Please mention Sum Assured for Secondary Life _____
- Increasing Life Cover, Please specify: 25% Increase 50% Increase
- Life Stage Cover Enhancement (This cannot be taken if Increasing Cover is Opted)

Death Benefit Payout Options:

- a) Lump Sum Monthly Income Lump Sum + Monthly Income
- b) No. of months of Monthly Income: 60 120
- c) Lump Sum Proportion _____ % (In case of Lump Sum + Monthly Income)

2. Strategy and fund allocation (to be filled in case of ULIP)

Please select Investment Strategy Defined Portfolio Strategy Life Stage Portfolio Strategy

To be filled if Defined Portfolio Strategy is selected: Please select the proportion in which you wish to invest your premiums (%) as per the options available within the product chosen

- Debt Fund _____% Large Cap Equity Fund _____% Growth Momentum Fund _____%
- Balance Fund _____% Multi Cap Opportunities Fund _____% Large Cap Advantage Fund _____%
- Growth Fund _____% Balanced Equilibrium Fund _____% Flexi Cap Opportunities Fund _____%
- Pramerica Nifty Mid Cap 50 Correlation Fund _____%

Systematic Transfer Plan		Yes		No
Single Premium Plan		6		12 <input type="checkbox"/> 24
Regular/Limited Pay		6		12

3. Details of Secondary Annuitant (to be filled incase of joint life annuity option)

Name: F I R S T M I D D L E L A S T
 Date of Birth: D D M M Y Y Y Y Gender: Male Female Transgender Relationship with Primary Annuitant _____

Section XII: Premium Payment Details (Cheque/ DD made payable to "Pramerica Life Insurance Limited" Application / Policy No. _____)

- 1. Method of Payment Debit Card Credit Card Cash DD / Cheque Others _____
- 2. Amount (in ₹). _____ 3. Cheque / DD No./Transaction I.D _____ 4. Bank Name & Branch Address _____
- 5. Is the Premium paid by a person other than Proposer? (If Yes, please submit third party declaration) Yes No
 Name _____ Relationship with Proposer _____ PAN No.: _____
- 6. Preference of Renewal Premium Online Credit Card SI Cheque Demand Draft ECS - Direct Debit ACH Cash

Section XIII: Policy Payout Details Account Type Current Savings

Bank Name _____ Branch Address _____
 Account Holder's Name _____ Account Number _____
 IFSC Code _____ MICR Code _____

As per IRDAI guidelines all future policy payouts shall be made in above account via NEFT. In case you close your account in future, kindly update your new banking details with us to avoid any payout inconvenience. Original cancelled cheque leaf to be enclosed / If cheque is not personalized please provide copy of latest bank statement in original or bank attested statement / passbook

Section XIV: Declaration, Agreement & Authorization

DECLARATION: I/We _____ have read this Application or got read/explained the Application, and furnished the information, after fully understanding the contents thereof. I/We have made complete, true and accurate disclosure of all facts to the best of my knowledge and belief and that I/We have not withheld any information. I/We hereby declare that the money used by me/us to pay the premium under this Application has not been derived from any criminal or illegal activity or any unknown sources. I hereby declare, on my behalf that the above statements, answers and/or particulars given by me are true and complete in all respects to the best of my knowledge and that I am authorized to propose on Life Insured's behalf. I understand that the information provided by me forms the basis of the insurance policy and that the policy is subject to the Board approved underwriting policy of Pramerica Life Insurance Limited ('PLIL') and that the cover will come into force and effect only after full receipt of the premium chargeable and upon issuance of the policy. I further declare that I will notify PLIL in writing of any change occurring in my occupation, financial health or general health after the proposal has been submitted but before communication of the risk acceptance by PLIL. I/We certify that I/We have provided the information on this form and to the best of my/our knowledge and believe the certification is true, correct, and complete including the taxpayer identification number of the applicant.

AGREEMENT: I/We do hereby agree that My/Our answers and/or statements provided herein and this declaration shall form the basis of policy issued by PLIL. In case of fraud, misstatement and concealment of material facts, contract shall be treated in accordance with Section 45 of the Insurance Act, 1938, as amended from time to time. If, after submission of this proposal and before issue of the policy, if an proposal for insurance on the life of the Proposed Insured/Proposed Holder made to any other insurance company or an proposal of revival, has been withdrawn or dropped or accepted at an increased premium or on terms other than as originally proposed, I/We shall forthwith intimate the same to PLIL in writing to reconsider the terms of acceptance of this proposal. The payment made along with the proposal is a deposit with PLIL to be adjusted towards premium in the event of acceptance of the risk sought to be insured by me/us. Unless accepted, no risk shall attach to PLIL. In the event that the proposal is found acceptable, PLIL shall be entitled to issue the policy commencing from any date subsequent to the date of submission of the proposal by me/us. I/we agree to undergo all medical tests required by PLIL as per its guidelines, including HIV-Elisa Test. The terms and conditions including the premium and benefits under the policy are subject to tax/duties/charges as per the applicable law. The information provided under this proposal will be used for the purpose of underwriting this proposal and for providing policy related services, in the event of the risk being accepted by PLIL. Any premium if paid by cash has to be paid only in PLIL branches and other authorized cash collection agencies against an official Receipt and not to PLIL's Financial Advisors/Broker/Corporate Agent. If it is paid to Financial Advisor/Broker/Corporate Agent for depositing with PLIL, then the Financial Advisor/Broker/Corporate Agent for this purpose is acting as my/our authorized representative and not that of PLIL and PLIL shall not be liable for any loss incurred by me/us while doing so. The policy will lapse in case the premiums are not paid as per the frequency and policy term opted in this form.

AUTHORIZATION: In order to enable the company to assess the risk under this proposal and anytime thereafter including at the time of claim processing, I/We hereby authorize the past and present employer(s), business associates, any life and nonlife company, hospitals, Govt. repositories (like Ayushman Bharat Health Account -ABHA), nursing homes, organizations, banks, financial institutions, tax and other authority(ies) or any third party(ies) to release to the company or its authorized third party agents details including but not limited to employment, business, financial, personal and medical records and provide such records or other details as may be considered relevant and further authorize the Company to obtain the same. I/we further consent that the information in this proposal has been given by me/us voluntarily and for the purpose of completion/servicing of this proposal or the resulting policy.

That I/We have voluntarily given my/our consent to collect, process, receive, possess, store, deal / handle / share my/our sensitive personal data or information (as defined in the Information Technology (Reasonable security practices and procedures and sensitive personal data or information) Rules 2011 as amended from time to time) for the purpose of processing of this Proposal or servicing of the resulting policy and claims related services, with regulated entities / third parties/ vendors associated with the Company including but not limited to Third Party Administrators, claim investigators, data analytics or any other entity which may be engaged for this purpose in accordance to the legal framework.

Signature / Thumb impression of Life Insured / Primary Life / Primary Annuitant

Date

Place _____

Signature / Thumb impression of Proposer / Secondary Life / Secondary Annuitant

Date

Place _____

Signature / Thumb impression of Witness

Name of Witness _____

Address of Witness _____

Declaration for signing in vernacular language or for uneducated person

I, (full name of declarant) _____, hereby declare that I have explained the contents of the proposal form to the Life Insured / Proposer in _____ language & that I have read out the answers to the questions dictated by me to the Life Insured / Proposer and that the Life Insured / Proposer has / have put his/her thumb impression after fully understanding the contents thereof.

Signature of the Declarant

Name _____

Address _____

Signature / Thumb impression of Proposer

Date

Place _____

Section XV: The Insurance Laws, as amended from time to time

Section 41 of the Insurance Act, 1938, as amended from time to time: 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 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 prospectus or tables of the insurer.

Section 45 of the Insurance Act, 1938, as amended from time to time: No policy of life insurance shall be called into question on any ground whatsoever after the expiry of three years from the date of policy. A policy of life insurance may be called into question at anytime within three years from the date of policy, on the ground of fraud or on the ground that any statement of or suppression of a fact material to the expectancy of the life of the insured was incorrectly made in the proposal or other document on the basis of which the policy was issued or revived or rider issued. The insurer shall have to communicate in writing to the insured or legal representatives or nominees or assignees of the insured, the grounds and materials on which such decision is based. No insurer shall repudiate a life insurance policy on the ground of fraud if the insured can prove that the misstatement or suppression of material fact was true to the best of his knowledge and belief or that there was no deliberate intention to suppress the fact or that such misstatement or suppression are within the knowledge of the insurer. In case of fraud, the onus of disproving lies upon the beneficiaries, in case the policyholder is not alive. In case of repudiation of the policy on the ground of misstatement or suppression of a material fact and not on the grounds of fraud, the premiums collected on the policy till the date of repudiation shall be paid. Nothing in this section shall prevent the insurer from calling for proof of age at any time if he is entitled to do so, and no policy shall be deemed to be called in question merely because the terms of the policy are adjusted on subsequent proof that the age of the life insured was incorrectly stated in the proposal. For complete details of the section and the definition of 'date of policy', please refer Section 45 of the Insurance Act, 1938, as amended from time to time.

Section XVI: Sales Person / Agent Confidentiality Report

I hereby declare that I have personally met the applicant, Life to be Insured, and the foregoing statements are true and correct to the best of my knowledge and enquiries made by me. I further state that the application form has been filled up by the Proposer/person authorized by the Proposer after fully understanding the nature of the questions in the application form and importance of disclosing all the material information has been explained by me to the Proposer. I have also explained the features and benefits of the plan and riders to the applicant.

- Do you know the Life to be Insured / Proposer? If Yes please provide relation _____
- Is the Life to be Insured physically handicapped / mentally retarded / has history of any illness / surgery or any medical investigations? Yes No
- Any other material information that may impact the company's underwriting decision? _____
- I confirm that the application form was signed by Mr /Ms _____, in front of me and I have verified it with the proof of signature submitted by the customer.

Signature of Sales Person _____

Name of Sales Person _____

Code & Designation _____

Date & Place _____

Signature of Supervisor _____

Name of Supervisor Name/Designation _____

Code & Designation _____

Date & Place _____

IRDAI Registration No. 140. Pramerica Life Insurance Limited. Registered Office and Communication Address: 4th Floor, Building No. 9, Tower B, Cyber City, DLF City Phase III, Gurgaon - 122002, Haryana. CIN: U66000HR2007PLC052028. For more details on risk factors, terms and conditions please read sales brochure carefully before concluding a sale. Customer Service Helpline Tel. No: 1860 500 7070 or 011 4818 7070 (Local charges apply) Timings: 9:30 a.m. to 6:30 p.m. (Monday-Saturday), SMS 'LIFE' to 5607070, Website: www.pramericalife.in, Email: contactus@pramericalife.in. The Pramerica mark displayed belongs to 'The Prudential Insurance Company of America' and is used by Pramerica Life Insurance Limited under license. APP/DF-ENG/23/NOV/21

For State Bank of India account only

Policy Holder Name: _____

Application/Policy No: _____

Instructions to fill Mandate: _____

- | | |
|--|---|
| <ol style="list-style-type: none"> 1. UMRN - Leave blank 2. Date in DD/MM/YYYY format 3. Sponsor Bank Code - Leave blank 4. Utility Code of Service Provider - Prefilled 5. Select whether the request is for mandate creation, cancellation or amendment - Mandatory 6. Name of Service Provider - Prefilled 7. Tick on box to select type of account - Mandatory 8. Customer's complete account number - Mandatory 9. Name of Bank and Branch where the account exists - Prefilled 10. IFSC/MICR Code of customer's bank - Mandatory | <ol style="list-style-type: none"> 11. Amount payable for service or maximum amount per transaction that could be processed, in words - Mandatory 12. Amount in figures, similar to the amount mentioned in words - Mandatory 13. Tick on box to select frequency of transaction - Mandatory 14. Debit type - tick on box to select Fixed or Maximum 15. Reference 1 allotted by Service Provider 16. Reference 2 generated by Service Provider 17. Mobile number of customer 18. Mail ID of customer 19. Validity period of mandate, with dates in DD/MM/YYYY format - Mandatory 20. Name(s) and Signature(s) of Accountholder(s) - Mandatory 21. Undertaking by customer - for information |
|--|---|

Terms & Conditions:

" I/We, understand and accept that this mandate signed on _____ Date _____ is for debiting my insurance premium due including applicable taxes and other statutory levies on opted debit date by National Automated Clearing House ("NACH") or through Direct Debit facility. I/We hereby express my/our unconditional and irrevocable consent to Pramerica Life Insurance Limited ("PLIL") to debit payment of the regular premium amount including applicable taxes and other statutory levies of my/our policy referred to above through participation in NACH facility offered by National Payments Corporation of India or through Direct Debit arrangement with the Banks. NACH or Direct Debit facility can be withdrawn/cancelled by giving 2 months advance to PLIL. PLIL has the right to withdraw NACH / Direct Debit facility anytime, if required on notification. I/We, understand and accept that the transaction will be effected at the frequency opted in NACH / Direct Debit mandate form. I/We, agree that if transaction gets delayed on account of incorrect/incomplete information or declined due to insufficient funds, PLIL shall in no way be held responsible. In case NACH / Direct Debit instruction gets bounced on the opted due date due to financial reasons, the NACH / Direct Debit transaction may be represented again for clearance. I/We, agree & understand that NACH / Direct Debit facility is available for Modal Premium only. Premium for Top-up should be paid by mode other than NACH/Direct Debit, as stipulated by the company. I/We, agree & understand that NACH / Direct Debit facility is available only after enforcement of the policy. Premium due before enforcement will be paid through other modes."

Proposer/Policy Holder's Signature
(As in Policy Application)

Pramerica | LIFE INSURANCE UMRN

Date

D	D	M	M	Y	Y	Y	Y
---	---	---	---	---	---	---	---

Sponsor Bank Code _____ Utility Code

5	1	1	8	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
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Tick (✓)
 CREATE
 MODIFY
 CANCEL

I/We hereby authorise Pramerica Life Insurance Limited to debit (tick ✓) SB / CA / CC / SB-NRE / SB-NRO / other

Bank a/c number _____

with Bank State Bank of India IFSC _____ or MICR _____

an amount of Rupees _____ ₹

FREQUENCY Mthly Qtly H-yrly Yrly As & when presented DEBIT TYPE Fixed Amount Maximum Amount

Reference 1 _____ Mobile No. _____

Reference 2 OPTIONAL Email ID _____

I agree for the debit of mandate processing charges by the Bank whom I am authorizing to debit my account as per latest schedule of charges of the Bank

PERIOD
From

D	D	M	M	Y	Y	Y	Y
---	---	---	---	---	---	---	---

To

D	D	M	M	Y	Y	Y	Y
---	---	---	---	---	---	---	---

Or Until cancelled

Signature primary Account Holder Signature of Account Holder Signature of Account Holder

1. Name as in bank records 2. Name as in bank records 3. Name as in bank records

"This is to confirm that the declaration has been carefully read, understood and made by me/us. I am authorizing the User entity/Corporate to debit my account. I have understood that I am authorized to cancel/amend this mandate by appropriately communicating the cancellation/amendment request to the User entity/Corporate or the Bank where I have authorized the debit."

Consent for Occupation Extra Premium (Only for Defense and Paramilitary Force Personnel) / Non Standard Age Proof^

I Mr. / Ms. / Mrs. _____, am aware that I will be paying an extra premium[§] of ₹_____ per thousand of Sum Assured[#] / Sum at Risk Due to submission of Non Standard age proof nature of my occupation, as classified by the guidelines of Pramerica Life Insurance Limited. I am aware that this amount will also be charged for all subsequent Premiums paid by me.*

Signature of Proposer

Date

D	D	M	M	Y	Y	Y	Y
---	---	---	---	---	---	---	---

Place _____

[^]For Non Standard Age proof, ₹2/- per thousand Sum Assured[#] /Sum at Risk will be applicable

^{*}For Traditional Products, this is charged for all subsequent premiums. For ULIP product this is charged from fund account.

[#]For traditional product, sum assured means death benefit at inception of policy

[§]For limited pay option this may be increased to allow for limited nature of the premium

Armed Services Questionnaire (To be Filled by Life Insured)

1. Please indicate your service: Army Navy Air Force Paramilitary

2. Please indicate Branch of Armed Service (Applicable for Paramilitary): _____

3. Do you currently engage in parachuting/ diving/ flying/ bomb disposal? Yes No

4. Please indicate your current medical category: SHAPE1 Others (Specify exact SHAPE category) _____ Not Applicable

I declare that all the answers I have given are, to the best of my knowledge, true and that I have not withheld any material information that may influence the assessment or acceptance of this application. I agree that this form will constitute part of my application for insurance and that failure to disclose any material fact known to me may invalidate the contract.

Signature of Life Insured

Date

D	D	M	M	Y	Y	Y	Y
---	---	---	---	---	---	---	---

Place _____