

Assuring Happiness.



PLI
डाक जीवन बीमा
Postal Life Insurance



RPLI
ग्रामीण डाक जीवन बीमा
Rural Postal Life Insurance

Low Premium. High Bonus.

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Share %age: %

Gender: M F

Date of Birth: / /

Age: Years

Communication Address

Village										Taluka									
City										District									
State										Country					PIN				

Phone No.

E-mail ID (If any)

ii. Second 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: % Gender: M F

Date of Birth: / / Age: Years

Communication Address

Village										Taluka									
City										District									
State										Country					PIN				

Phone No.

E-mail ID (If any)

iii. Third 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: % Gender: M F

Date of Birth: / / Age: Years

Communication Address

Village										Taluka									
City										District									
State										Country					PIN				

Phone No.

E-mail ID (If any)

b. Appointee Details (If nominee is minor)

First Name										Middle Name										Last Name									
------------	--	--	--	--	--	--	--	--	--	-------------	--	--	--	--	--	--	--	--	--	-----------	--	--	--	--	--	--	--	--	--

Relationship: Gender: M F

Date of Birth: / / Age: Years

- (viii) HIV Positive/ AIDS or any other sexually transmitted diseases : Yes No Yes No
- (ix) Hepatitis-B or C or A : Yes No Yes No
- (x) Epilepsy : Yes No Yes No
- (xi) Nervous disorder, Gastritis, Stomach or duodenal Ulcer, Hernia : Yes No Yes No
- (xii) symptoms /ailment relating to liver or reproductive system : Yes No Yes No
- (xiii) Leprosy : Yes No Yes No
- (xiv) Any physical deformity or handicap : Yes No Yes No
- (xv) Any other serious disease : Yes No Yes No

c. Has any of your family members (Father, Mother, Brothers or Sisters) living or dead suffered from any hereditary or infectious disease like, Insanity/ Epilepsy/ Gout/ Asthma/ Tuberculosis/ Cancer/ Leprosy etc?

Yes No

If yes, give details: _____

d. Have you availed any kind of leave on medical ground or hospitalized during the last 3 years? If so, furnish the following information.

	Kind of leave	Period of leave	Ailment	Name of Hospital	Period of Hospitalization	
					From	To
1.						
2.						
3.						

e. Do you have any physical deformity or congenital by birth defects? (Yes/ No) _____

i. If yes, Type of deformity (Congenital/ Non-Congenital): _____

ii. In case of congenital deformity, please state whether it is Blindness/ Deafness/ Dumbness/ Orthopaedic Handicap of One Limb/ Loss of one limb/Midgets/Hunchback _____

iii. In case of non-congenital deformity, please state whether it is Blindness/ Deafness/ Dumbness/ Orthopaedic Handicap of One Limb/ Loss of one limb _____

iv. In case of congenital/ non-congenital deformity, please state whether it is Orthopaedic Handicap of both Limbs/ Loss of both limbs/ Mentally retarded having mental age of 14 or above/ Weakness or deformity/ Paralysis due to Polio/ Any other deformity of non-neurological origin _____

f. Particulars of the family doctor, if any: _____

12. Additional Health Information (Required in case of Sum Assured/ Aggregate Sum Assured is above ₹20 lakh)

- | | Proponent | Spouse (if Yugal Suraksha) |
|---|--|--|
| (i) Are you currently undergoing/have undergone any tests, investigations, awaiting results of any tests, investigation or have you ever been advised to undergo any tests, investigations or surgery or been hospitalised for general check-up, observations, treatment or surgery | : Yes <input type="checkbox"/> No <input type="checkbox"/> | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| (ii) Diabetes/ High Blood Sugar | : Yes <input type="checkbox"/> No <input type="checkbox"/> | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| (iii) High/ Low Blood Pressure | : Yes <input type="checkbox"/> No <input type="checkbox"/> | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| (iv) Have you ever been referred to an Oncologist or cancer hospital for any investigation or treatment | : | |
| (v) Did you have any ailment/injury/accident requiring treatment//medication for more than a week | : Yes <input type="checkbox"/> No <input type="checkbox"/> | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| (vi) Have you ever suffered Thyroid dis- order or any other disease or disorder of the endocrine system | : Yes <input type="checkbox"/> No <input type="checkbox"/> | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| (vii) Ave you undergone/have been recommended to undergo Angioplasty , bypass surgery, brain surgery, Heart valve surgery Aorta surgery or organ transplant | : Yes <input type="checkbox"/> No <input type="checkbox"/> | Yes <input type="checkbox"/> No <input type="checkbox"/> |

- (viii) Have you ever suffered disorders of eye, ear, nose, throat, including defective sight speech or hearing & discharge from ears : Yes No Yes No
- (ix) Have you ever suffered Anaemia, blood or blood related disorders : Yes No Yes No
- (x) Have you ever suffered musculoskeletal disorders such as arthritis, recurrent back pain, slipped disc or any other disorder of spine, joints, limbs or leprosy : Yes No Yes No

12.1 Additional Health Information for Female Proponent (In case of Sum Assured or Aggregate Sum Assured exceeding ₹20 lakh)

- i. Have you ever have any abortion, miscarriage or ectopic pregnancy : Yes No
- ii. Have you ever undergone any gynaecological investigations, internal checkups, breast checkups such as mammogram or biopsy : Yes No
- iii. Have you ever consulted a Doctor because of an irregularity at the breast, vagina, uterus, ovary, fallopian tubes, menstruation, birth delivery, complications during pregnancy or child delivery or a sexually transmitted diseases? : Yes No

13. Personal habits of the proponent impacting health (Required in case of Sum Assured/ Aggregate Sum Assured is above ₹20 lakh)

If Yes, Whether Frequently or Occasionally

- (i) Do you Smoke/ Consume Tobacco? : Yes No Frequently Occasionally
- (ii) Do you Consume Alcohol? : Yes No Frequently Occasionally
- (iii) Do you Consume Drugs? : Yes No Frequently Occasionally
- (iv) Do you have any habits, which can adversely impact your health? : Yes No If yes, furnish details _____

14. Suitability Analysis(Required in case of Sum Assured/ Aggregate Sum Assured is above ₹20 lakh)

i. Affordable Contribution

YEAR	Last Year	Current Year	Next 5-10 Yrs	Next 10-15 Yrs	Next 15-20 Yrs	Next 20-25 Yrs	Next 25-30 Yrs
a. Yearly							
b. Monthly							

ii. Income/ Expenditure – Current and Projected (in ₹)

YEAR	Last Year	Current Year	Next 5-10 Yrs	Next 10-15 Yrs	Next 15-20 Yrs	Next 20-25 Yrs	Next 25-30 Yrs
a. Income							
b. Expenditure							

iii. Financial Details (in ₹)

a.Value of Savings and Assets	
b.Details	

iv. Family/ Dependent Details

Particulars	1	2	3	4
a. Names of family members/ dependents				
b .Male/ Female				
c. Relationship				
d. Date of Birth				
e. Occupation				
f. Whether financially dependent				

15. Declaration of Proponent/ Spouse (Spouse signature is required in case of Yugal Suraksha Policy)

(A) I/ We do hereby declare that (a) no proposal of insurance on my/ our life/ lives has ever been adversely treated by any insurance company (b) the foregoing statements made are true to the best of my/ our knowledge and belief (c) in case it is found that I/ we have wilfully made any untrue statement or have concealed any relevant circumstances then all the premia which shall have been paid by me/ us, shall be forfeited and this contract rendered absolutely null and void (d) I/ We understand that my/ our life/ lives shall be insured from the date my proposal is accepted (e) I/ We have gone through the terms and conditions for insurance with PLI, a copy of which has been given to me/ us and explained to me/ us in my language. I/ We hereby agree to abide by them.

*I further declare that:

- 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.
- 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.
- 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.
- The discontinued policy shall not attract bonus with effect from the date from which the premium is discontinued.
- 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.
- 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.

*Surrender is applicable for WLA, CWA, EA & YS policies.

(B) I/We _____ Son /wife /daughter of _____
 aged _____ years & _____ Son /wife /daughter of _____
 aged _____ years do hereby declare that:

I/We am/are not suffering from Hypertension & Diabetes and not taking any treatment for Hypertension & Diabetes.

OR

I/We have been suffering from Diabetes/Hypertension for the Last _____ years but with proper medical advice & medication it is with in control and no complication has surfaced so far posing any threat to my life.

(C) I/ We hereby agree to pay the fee of ₹ _____
 (per individual) for the medical examination if our proposal is not accepted.

Spouse's Signature: _____

Proponent's Signature: _____

Dated: The _____ Day of _____ 20_____

16. Certificate of Immediate Superior

Certified that _____ is a permanent/ temporary employee in _____ and information furnished against column No. 1 to 5 & 11 (d) of this proposal form is correct as per his/ her service records.

Date : _____

Signature: _____

Place: _____

Name : _____

Designation/Seal: _____

17. To be filled in by DO/ FO (PLI)/ Agent/ Sales Force

i. In case Sum Assured/ Aggregate Sum Assured is less than/ equal to ₹20 lakh.

I _____ Agent Code No./ ID _____ certify that the information in the proposal form has been furnished by the proponent and it has been signed by him/ his thumb impression has been taken 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: _____

Agent's Signature: _____

ii. In case Sum Assured/ Aggregate Sum Assured is above ₹20 lakh.

1. Life Stage	Childhood/ Young unmarried/ Young married/ Young married with children/ married with older children/ post-family or pre-retirement/ retirement
2. Protection needs	Life & Health/ Savings and Investment/ Pension
3. Appetite for risk	Low/ Medium/ High
4. Policy recommended, including name of insurer	
5. Details of commitment for the current and future years	
6. Whether all risk elements and details of charges to be incurred and all other obligations have been explained?	
7. Why do you think this policy is most suited for the proposer?	
8. Whether product proposed is:	
i. Based on need	
ii. Based on demand	
iii. Based on Agent's recommendation	

iii. Details to be entered in all cases by Agent/DO/FO (PLI)/Sales Person/ Broker.

Policy Type: _____ Sum Assured: _____ Age at entry: _____ Premium rate: ₹ _____
Receipt LI-7(a) No. : _____ Date: _____/_____/20____ Amount Collected from Proponent: ₹ _____
Name of Medical Officer: _____ Code No. of Medical Officer: _____
Post Office where payment is being deposited: _____

DO/FO (PLI)/Agent/ Sales person's / Broker's Certification:

I/We hereby certify that I/we believe that the product(s) recommended by me/us above is suitable for the proposer, based on the information submitted by him/her, as recorded above. I/We declare that the policy recommended has been fully explained to the proposer, including about the terms and conditions, exclusions, premium commitments and various charges, as applicable.

Dated: _____

(Signature of Agent/DO/FO (PLI)/Sales Person/ Broker)

Proposer's Acknowledgement

The above recommendation is based on the information provided by me. I have been explained about the features of the product and I believe, it would be suitable for me based on my insurance needs and financial objectives.

Dated: _____

(Signature/Thumb Impression of Proposer)

18. Medical Examiner's Certificate:

Certified that I have carefully examined Shri/ Smt. _____ the proponent,
and Shri/ Smt. _____ the spouse,
whose signature is/ are given below today the _____ Day of _____ 20_____.

On careful examination of the proponent and after going through the information furnished by him/ her under column 12 and reports of prescribed medical tests, I find the proponent/ spouse to be medically fit. He/ She/ They does/ do not suffer from any terminal or other serious health hazard which would be risk to his/ her/ their life. I recommend acceptance of his/ her/ their proposal of Postal Life Insurance policy.

OR

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

Signature of Proponent: _____

Signature of Medical Examiner: _____

Name: _____

Seal : _____

Date : _____

Signature of Spouse: _____

ID/ Code : _____

(In case of Yugal Suraksha)

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.

Tests required in case Sum Assured or Aggregate Sum Assured is more than ₹20 lakh

d) Supplementary Bio- Chemical Tests [SBT -13]

- 1. Fasting Blood Sugar- Method _____ , 2.Total Cholesterol, 3. High Density, Lipid [HDL], 4.Low Density Lipid [LDL] 5. S Triglycerides, 6 S Creatinine,7. Blood Urea Nitrogen - a. Albumin, b Globulin, 8. © AG Ratio – S Bilirubin- a .Direct, b. Indirect c Total 9. SGOT [AST], 10. GGTP [ALT] 11. S Alkaline Phosphate, 12 Hbs AG [Australia antigen] & 13. Elisa for HIV [Method _____].

e. Following tests are required to be conducted:

- Age up to 35 years- ECG, Routine Urine Analysis, SBT 13, Hb %
- Age between 36 to 45 ECG, Routine Urine Analysis, SBT 13, Hb %. CTMT, Hemogram
- Age between 46 to 55 years ECG, Routine Urine Analysis, SBT 13, Hb %. CTMT, Hemogram, Hb Alc
- Age of 56 years & above ECG, Routine Urine Analysis, SBT 13, Hb %. CTMT, Hemogram, Hb Alc
- [Policy Revival cases] X ray of chest



Affix here your recent passport size photograph

**DEPARTMENT OF POSTS
PROPOSAL FORM FOR RURAL POSTAL LIFE INSURANCE (RPLI)**

(All entries should be filled in CAPITAL letters)
Agent/Advisor Code: _____

Agent/ Sales person Name: _____ Group Leader Name & Code: _____

Proposal Date

d	d	/	m	m	/	y	y	y	y
---	---	---	---	---	---	---	---	---	---

 Date of Declaration

d	d	/	m	m	/	y	y	y	y
---	---	---	---	---	---	---	---	---	---

Product/ Policy Type: WLA CWLA EA AEA GY
Do you already have any PLI/RPLI policy: Yes / No
Customer ID _____ (for existing customers)

1. Proposer's Details:

i. Name of Proponent Mr. Mrs. Ms.)

First Name	Middle Name	Last Name
------------	-------------	-----------

ii. Aadhaar No. _____ (optional) iv. PAN _____ (optional)

iii. Father's Name OR Mother's Name

First Name	Middle Name	Last Name
------------	-------------	-----------

iv. Gender M F Others v. Date of Birth (dd/mm/yyyy)

d	d	/	m	m	/	y	y	y	y
---	---	---	---	---	---	---	---	---	---

 vi. Marital Status Married Unmarried Others

vii. Age Proof: [Tick (√) whichever is applicable]
(Standard Age Proof)
 Birth Certificate Matriculation Certificate Driving License Passport PAN Others
Non standard Age Proof: _____ (please specify)

vi. **FOR FEMALE PROPONENT ONLY**
Number of Children

--	--

 Are you Pregnant now?

Yes		No	
-----	--	----	--

 If pregnant, expected month of delivery

--	--	--	--	--	--	--	--	--	--

2. Contact Details

i Correspondence Address Tick here if permanent address is same (√)

Correspondence Address:	Permanent Address:
Village/Locality: _____ Post Office: _____ Taluka/District: _____ State: _____ Pincode: _____ Mobile No: _____ Email address: (if any) _____	Village/Locality: _____ Post Office: _____ Taluka/District: _____ State: _____ Pincode: _____ Mobile No: _____ Email address: (if any) _____

3. Proposer's Occupation and Income Details:

Occupation: _____

PAN No. (if any)	
Monthly Income	

4. Nomination Details (refer Section 39 of Insurance act 1938)

a. **Details of Nomination** (Not more than 3 nominees)

Name & address of the Nominee(s)	Gender (M/F/Other)	Date of Birth (DD/MM/YYYY)	Aadhaar No. (optional)	Relationship	Share of Nominee(s) %	Mobile & email ID
1.						
2.						
3.						

9. Declaration of Proponent

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 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 increase 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 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.
- g)

I _____ Son/ Wife/ Daughter of _____ aged ____ years do hereby declare that:

i. I _____ am not suffering from Hypertension & Diabetes and not taking any treatment for Hypertension & Diabetes.

OR

I have been suffering from Diabetes/Hypertension from the last _____ years but with proper medical advice & medication it is with in control and no complication has surfaced so far posing any threat to my life.

_____ hereby agree to pay the fee of ₹ _____ (per individual) for the medical examination if my proposal is not accepted.

The above recommendation is based on the information provided by me. I have been explained about the features of the product and I believe, it would be suitable for me based on my insurance needs and financial objectives.

Proponent's Signature /
Thumb Impression
(in case proposer is illiterate)



Dated:

d	d	/	m	m	/	y	y	y	y
---	---	---	---	---	---	---	---	---	---

10. Declaration in case the proposer is illiterate, and form is filled by person other than proposer

I _____ hereby declare that I have explained the content of this form to the proposer in _____ (Language) which he/she easily understands and that the proposer has affixed the thumb impression above after fully understanding the contents there of. I have carefully filled up the proposal form.

Signature:



Declarant's Name: _____

Address: _____

Date:

d	d	/	m	m	/	y	y	y	y
---	---	---	---	---	---	---	---	---	---

11. Declaration by Agent/Sales Person

I _____ Agent Code No./ID _____ working as _____ in _____ BO/SO under _____ Division declare that the information (personal, financial & medical) in the proposal form has been furnished by the proponent and it has been signed by him/his thumb impression has been taken in my presence. All columns have been completed and have been verified and found correct to best of my knowledge. I am fully aware about financial/physical/mental situation concerning proposer which makes him suitable/unsuitable for the consideration of his Insurance proposal. The proposal is recommended/not recommended for acceptance. I further undertake that I have carried out required verification and completed the confidential report & enclosed with this proposal form.

Date:

d	d	/	m	m	/	y	y	y	y
---	---	---	---	---	---	---	---	---	---

Signature with Stamp:



Mobile Number: -.....

Email Id: -.....

Notes/Instructions for filling up the Proposal Form (Not to be scanned & uploaded)

1. Please provide valid proof of your age. In case you are not having any valid proof of date of birth you may produce any of the following documents (non standard age proof)* :
 - a. Self-declaration attested by Panchayat member/gram Pradhan.
 - b. Medical officer's appropriate age certificate.
 - c. Voter ID bearing age.
 - d. Aadhar Card

(*policy(ies) taken on non standard age proof will be charged 5% additional premium)
2. Please mention your mobile number, email ID at appropriate place. Mentioning mobile number and email address will help us in sending SMS and e-mail alerts to you for various services of .
3. Nomination in Policy will help in timely and hassle-free settlement of claim, if a policy becomes a claim before date of maturity. Therefore, it is advisable to give nominee (s) details in each case.
4. In case policy is taken under Married Women Property Act 1874, nomination in such case is not required. In such case name of the beneficiary (i.e. wife) should be mentioned at serl 4 © of proposal form
5. Mentioning Aadhar/ PAN is optional. However, it would facilitate us to provide better after sales services.
6. In case of change of address/nomination, proponent is advised to notify the same to nearest CPC concerned.
7. In case, nominee is minor, particulars of person as appointee should be given at appropriate place.
8. Please mention your Bank Account No. or Post Office Account, if any.
9. Willful concealment of any material information will render the contract voidable at any time.
10. Change of communication address, mobile number or email address may be brought to information of Department to avail better after sales service.
11. 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 Deptt. and this declaration should be made by him.

- (xiii) Leprosy : Yes No Yes No
- (xiv) Any physical deformity or handicap : Yes No Yes No
- (xv) Any other serious disease : Yes No Yes No

c. Has any of your family members (Father, Mother, Brothers or Sisters) living or dead suffered from any hereditary or infectious disease like, Insanity/ Epilepsy/ Gout/ Asthma/ Tuberculosis/ Cancer/ Leprosy/ Diabetes etc?

: Yes No

If yes, give details: _____

d. Have you availed any kind of leave on medical ground or hospitalized during the last 3 years? If so, furnish the following information.

	Kind of leave	Period of leave	Ailment	Name of Hospital	Period of Hospitalization	
					From	To
1.						
2.						
3.						
4.						
5.						
6.						

e. Do you have any physical deformity or congenital by birth defects? (Yes/ No) _____

i. If yes, Type of deformity (Congenital/ Non-Congenital): _____

ii. In case of congenital deformity, please state whether it is Blindness/ Deafness/ Dumbness/ Orthopedic Handicap of One Limb/ Loss of one limb/ Midgets/ Hunchback _____

iii. In case of non-congenital deformity, please state whether it is Blindness/ Deafness/ Dumbness/ Orthopedic Handicap of One Limb/ Loss of one limb _____

f. Particulars of the family doctor, if any: _____

11. Declaration of Proponent/ Spouse

(A) I/ We do hereby declare that (a) no proposal of insurance on my/ our life/ lives has ever been adversely treated by any insurance company (b) the foregoing statements made are true to the best of my/ our knowledge and belief (c) in case it is found that I/ we have wilfully made any untrue statement or have concealed any relevant circumstances then all the premia which shall have been paid by me/ us, shall be forfeited and this contract rendered absolutely null and void (d) I/ We understand that my/ our life/ lives shall be insured from the date my proposal is accepted (e) I/ We have gone through the terms and conditions for insurance with PLI, a copy of which has been given to me/ us and explained to me/ us in my language. I/ We hereby agree to abide by them.

I further declare that:

- 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.
- 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.
- 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.
- The discontinued policy shall not attract bonus with effect from the date from which the premium is discontinued.
- 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.
- 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.
- MY MEDICAL CATEGORY IS SHAPE-1 (Applicable for Defence and Para Military pers only)
- In the event of my proposal dated _____ for Postal Life Insurance Policy for the sum of Rs _____ being accepted, I hereby authorize Addl DG APS, IHQ of MoD (Army) to direct _____ (Name of PAO), being the office maintaining my pay accounts, to deduct from my pay a sum equal to the amount of the first premium and subsequent premia payable by me with effect from the month of acceptance of PLI proposal in respect of the said insurance, to receive the said sum from him and apply it towards payments of the said premium.

(B) I/ We hereby agree to pay the fee of ₹ _____ (per individual) for the medical examination if our proposal is not accepted.

Spouse's Signature: _____

(Signature of the proposer with service No)

No _____ Rank _____

Name _____

Present unit/office address _____

with PIN Code _____

Dated: The _____ Day of _____ 20 _____

12. Certificate of Immediate Superior

(a) Certified that No _____ Rank _____ Name _____ is a permanent/ temporary employee in _____ and information furnished against column No. 1 to 5 of this proposal form is correct as per his/ her service records.

(b) It is also certified that the medical category of the above proposer is SHAPE-1 as per his last Medical Examination carried out on _____ (Not applicable for personnel of GREF, Def Civilians/Non Medical Cases).

(c) The form is countersigned in respect of declaration at Serial 11 A(h) above.

Date : _____

Signature: _____

Place: _____

Name : _____

Designation/Seal: _____

13. To be filled in by DO/ FO (PLI)/ Agent

I No _____ Rank _____ Name _____ Agent Code No./ ID _____ certify that the information in the proposal form has been furnished by the proponent and it has been signed by him/ his thumb impression has been taken 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: _____

DO/FO/Agent's Signature: _____
No _____ Rank _____
Name _____

14. Medical Examiner's Certificate:

Certified that I have carefully examined Shri/ Smt. No _____ Rank _____ Name _____ the proponent, and Shri/ Smt. _____ the spouse, whose signature is/ are given below today the _____ Day of _____ 20_____.

On careful examination of the proponent and after going through the information furnished by him/ her under column 12, I find the proponent/ spouse to be medically fit. He/ She/ They does/ do not suffer from any terminal or other serious health hazard which would be risk to his/ her/ their life. I recommend acceptance of his/ her/ their proposal of Postal Life Insurance policy.

OR

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

Signature of Proponent: _____

Signature of Medical Examiner: _____
Name: _____
Seal : _____
Date : _____
ID/ Code : _____

Signature of Spouse: _____
(In case of Yugal Suraksha)

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.

15. Unit Code with Details of Proposal Checked by:

Unit Code	<input type="text"/>	Sig	Field Officer	DA	Asst PO	OC (With Rubber Stamp)

**DEPARTMENT OF POSTS
PROPOSAL FORM FOR CHILDREN POLICY (APS)**

Affix here
Child's recent
passport size
photograph

All entries should be filled in CAPITAL letter:

FOR OFFICIAL USE ONLY	
Name of the Development Officer/ FO/ Agent/ Postal Employee (ASP/ IPO/ PM/ PA/ SA/ Postman/ Mail Guard/ MTS/ GDS BPM/ GDS DA/ GDS MC) <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	Proposal No. <div style="border: 1px solid black; height: 20px; width: 100%;"></div>
Agent Code <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	Date of Receipt <div style="border: 1px solid black; height: 20px; width: 100%;"></div>
	No. of LI-7(a) <div style="border: 1px solid black; height: 20px; width: 100%;"></div>
Amount deposited ₹ <div style="border: 1px solid black; width: 40px; height: 20px; display: inline-block;"></div>	Post Office at which deposited <div style="border: 1px solid black; height: 20px; width: 100%;"></div>
	ACG-67 Receipt No. and Date <div style="border: 1px solid black; height: 20px; width: 100%;"></div>
	Policy No. <div style="border: 1px solid black; height: 20px; width: 100%;"></div>

Proposal Date (DD/MM/YYYY)

Date of Declaration (DD/MM/YYYY)

Product/ Policy Type PLI

1. Child's Details

i. Name of Child

First Name	Middle Name	Last Name

ii. Father's Name

iii. Mother's Name

iv. Gender v. Date of Birth (DD/MM/YYYY) vi. Parent's Policy Number

M F

vi. Age Proof: [Tick (✓) whichever is applicable] (Standard Age Proof)

Birth Certificate Matriculation Certificate Driving License Passport PAN

vii. Nationality

2. Address Details

i. Communication Address: **UNIT PIN CODE**

ii. Permanent Address

Village	Taluka
City	District
State	Country
PIN	

3. Contact Details

i. Phone No. with STD Code

ii. Mobile No.

8. Health Information

a. Are you and your child in sound health at present? Yes No

b. Have your child ever suffered/ suffering from any of the following? (Say Yes or No)

		Child	
		Yes	No
(i)	Tuberculosis	Yes <input type="checkbox"/>	No <input type="checkbox"/>
(ii)	Cancer	Yes <input type="checkbox"/>	No <input type="checkbox"/>
(iii)	Paralysis	Yes <input type="checkbox"/>	No <input type="checkbox"/>
(iv)	Insanity	Yes <input type="checkbox"/>	No <input type="checkbox"/>
(v)	Any disease of heart and lungs	Yes <input type="checkbox"/>	No <input type="checkbox"/>
(vi)	Kidney disease	Yes <input type="checkbox"/>	No <input type="checkbox"/>
(vii)	Any disease of brain	Yes <input type="checkbox"/>	No <input type="checkbox"/>
(viii)	HIV Positive	Yes <input type="checkbox"/>	No <input type="checkbox"/>
(ix)	Hepatitis-B	Yes <input type="checkbox"/>	No <input type="checkbox"/>
(x)	Epilepsy	Yes <input type="checkbox"/>	No <input type="checkbox"/>
(xi)	Nervous disorder	Yes <input type="checkbox"/>	No <input type="checkbox"/>
(xii)	Liver	Yes <input type="checkbox"/>	No <input type="checkbox"/>
(xiii)	Leprosy	Yes <input type="checkbox"/>	No <input type="checkbox"/>
(xiv)	Any physical deformity or handicap	Yes <input type="checkbox"/>	No <input type="checkbox"/>
(xv)	Any other serious disease	Yes <input type="checkbox"/>	No <input type="checkbox"/>

c. Has any of your family members (Father, Mother, Brothers or Sisters) living or dead suffered from any hereditary or infectious disease like, Insanity/ Epilepsy/ Gout/ Asthma/ Tuberculosis/ Cancer/ Leprosy/ Diabetes etc?

Yes No

If yes, give details: _____

d. Have child hospitalized during the last 3 years? If so, furnish the following information.

	<u>Ailment</u>	<u>Name of Hospital</u>	<u>Period of Hospitalization</u>	
			<u>From</u>	<u>To</u>
1.				
2.				
3.				

e. Does the child any physical deformity or congenital by birth defects? (Yes/ No) _____

i. If yes, Type of deformity (Congenital/ Non-Congenital): _____

ii. In case of congenital deformity, please state whether it is Blindness/ Deafness/ Dumbness/ Orthopedic Handicap of One Limb/ Loss of one limb/ Midgets/ Hunchback _____

iii. In case of non-congenital deformity, please state whether it is Blindness/ Deafness/ Dumbness/ Orthopedic Handicap of One Limb/ Loss of one limb _____

f. Particulars of the family doctor, if any: _____

9. Declaration of Parent

(A) I do hereby declare that (a) no proposal of insurance on life of above named child has ever been adversely treated by any insurance company (b) the foregoing statements made are true to the best of my knowledge and belief (c) in case it is found that I have wilfully made any untrue statement or have concealed any relevant circumstances then all the premia which shall have been paid by me, shall be forfeited and this contract rendered absolutely null and void (d) I understand that child's life shall be insured from the date my proposal is accepted (e) I have gone through the terms and conditions for insurance with PLI, a copy of which has been given to me and explained to me in my language. I hereby agree to abide by them.

(B) I hereby agree to pay the fee of ₹ _____ (per individual) for the medical examination if our proposal is not accepted.

Parent's Signature: _____

(Signature with service No)

No _____ Rank _____

Name _____

Present unit/office address _____

with PIN Code _____

Dated: The _____ Day of _____ 20____

10. Certificate of Immediate Superior

(a) Certified that No _____ Rank _____ Name _____ is a permanent/ temporary employee in _____ and information furnished against column No. 1 to 4 of this proposal form is correct as per his/ her service records.

Date : _____ Signature: _____
 Place: _____ Name : _____
 Designation/Seal: _____

11. To be filled in by DO/ FO (PLI)/ Agent

I No _____ Rank _____ Name _____ Agent Code No./ ID _____ certify that the information in the proposal form has been furnished by the proponent and it has been signed by him/ his thumb impression has been taken 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: _____ DO/FO/Agent's Signature: _____
 No _____ Rank _____
 Name _____

12. Medical Examiner's Certificate:

Certified that I have carefully examined Master/ Shri/ Ms. _____ the proponent whose signature is given below today the _____ Day of _____ 20_____.

On careful examination of the proponent and after going through the information furnished by him/ her under column 11, 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 Child: _____ Signature of Medical Examiner: _____
 Name: _____
 Seal : _____
 Date : _____
 ID/ Code : _____

NOTE FOR MEDICAL OFFICER

- a) When there are two or more cases of diabetes in the family, report of Glucose² 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.

13. Declaration for Recovery of Premia

In the event of my proposal for my son/daughter dated _____ for Postal Life Insurance Policy for the sum of Rs _____ being accepted. I hereby authorise Addl DG APS, IHQ of MoD (Army) to direct _____ (Name of PAO), being the office maintaining my pay accounts, to deduct from my pay a sum equal to the amount of the first premium and subsequent premia payable by me with effect from the month of acceptance of PLI proposal in respect of the said insurance, to receive the said sum from him and apply it towards payments of the said premia.

Station: _____ Signature: _____
 Dated: _____ No _____ Rank _____
 Name _____

COUNTERSIGNED

Dated: _____ (Signature of Officer with name and designation stamp)
 Seal _____

14. Unit Code with Details of Proposal Checked by:

Unit Code	<input type="text"/>	Sig	Field Officer	DA	Asst PO	OC (With Rubber Stamp)

DEPARTMENT OF POSTS
PROPOSAL FORM FOR CHILDREN POLICY

Affix here
Child's recent
passport size
photograph

All entries should be filled in CAPITAL letter:

FOR OFFICIAL USE ONLY	
Name of the Development Officer/ FO/ Agent/ Postal Employee (ASP/ IPO/ PM/ PA/ SA/ Postman/ Mail Guard/ MTS/ GDS BPM/ GDS DA/ GDS MC)	Proposal No.
	Date of Receipt
	No. of LI-7(a)
Agent Code	Amount deposited ₹
	Post Office at which deposited
	ACG-67 Receipt No. and Date
	Policy No.

Proposal Date (DD/MM/YYYY)
/ /

Date of Declaration (DD/MM/YYYY)
/ /

Product/ Policy Type PLI

RPLI

1. Child's Details

i. Name of Child
First Name Middle Name Last Name

ii. Father's Name

iii. Mother's Name

iv. Gender M F v. Date of Birth (DD/MM/YYYY) / / vi. Parent's Policy Number

vi. Age Proof: [Tick (✓) whichever is applicable] (Standard Age Proof)
Birth Certificate Matriculation Certificate Driving License Passport PAN

(Non-Standard Age Proof) (In case of RPLI only)
Horoscope Elder's Declaration Aadhaar Card Medical Examiners Approximate age certificate

Dec by insurant counter signed by Panchayat Member Only month year of Birth is known

vii. Nationality

2. Address Details

i. Communication Address (If Permanent Address is same as Communication Address please ✓ in the box)

Village	Taluka	
City	District	
State	Country	PIN

ii. Permanent Address

Village	Taluka	
City	District	
State	Country	PIN

3. Contact Details

i. Phone No. with STD Code

ii. Mobile No.

iii. E-mail ID (If any)

4. Parent's Employment/ Occupation Details

i. Occupation:

Central Govt State Govt PSU Railway Bank Telecom Contractual Joint Venture
 Defence Para Military Force Cooperative Society Deemed University/ Educational Institution
 Agriculture Teacher Carpenter Labour Tailor Blacksmith Doctor Cobbler
 Fisherman Postmaster Goldsmith Canner Priest Mason Potter Electrician
 Housewife Weaver Dhobi Barber Milk vendor Business Vegetable vendor Driver
 Mechanic Mid wife Govt employee Private employee Un-employed Student Taper
 Toddy worker Other (Please specify) _____

ii. Name of Organization: _____

iii. Designation _____

iv. Date of Entry in Service _____ / _____ / _____
 v. Designation of Immediate Superior _____

vi. PAN No. _____
 vii. Monthly Income ₹ _____
 viii. DDO Code _____

ix. Office Address

Village		Taluka	
City		District	
State		Country	PIN

x. Office Phone No. with STD Code _____
 xi. Official E-mail ID (If any) _____

xii. Qualification
 Post Graduate Graduate Diploma Se. Sec. Education High School Middle Class Primary Education
 Illiterate Other (furnish detail) _____

5. Additional Policy Details Held by Parents

i. Particulars of other PLI/ RPLI policies already held, if any:

	Policy No.	Type	Sum Assured (in ₹)	Maturity Date
1.				
2.				
3.				
4.				
5.				
6.				
Total: (in ₹)				

ii. Particulars of life insurance policies of other companies already held, if any:

	Policy No.	Type	Insurer	Sum Assured (in ₹)	Maturity Date
1.					
2.					
3.					
4.					
5.					
6.					
Total: (in ₹)					

6. Coverage Details

i. Age at Maturity _____ Years
 ii. Policy Term _____ Years
 iii. Sum Assured ₹ _____

7. Premium Details

i. Premium ₹ _____ / -
 ii. Initial Premium Payment Mode _____
 iii. Subsequent Premium Payment Mode _____
(Cash/ Cheque/ Credit Card/ Debit Card/ Salary)

iv. Premium Payment Frequency
 Monthly

8. Health Information

a. Are you and your child in sound health at present? **Yes** **No**

b. Has your child ever suffered/ suffering from any of the following? (Say Yes or No)

		Child	
		Yes	No
(i)	Tuberculosis	Yes <input type="checkbox"/>	No <input type="checkbox"/>
(ii)	Cancer	Yes <input type="checkbox"/>	No <input type="checkbox"/>
(iii)	Paralysis	Yes <input type="checkbox"/>	No <input type="checkbox"/>
(iv)	Insanity	Yes <input type="checkbox"/>	No <input type="checkbox"/>
(v)	Any disease of heart and lungs	Yes <input type="checkbox"/>	No <input type="checkbox"/>
(vi)	Kidney disease	Yes <input type="checkbox"/>	No <input type="checkbox"/>
(vii)	Any disease of brain	Yes <input type="checkbox"/>	No <input type="checkbox"/>
(viii)	HIV Positive	Yes <input type="checkbox"/>	No <input type="checkbox"/>
(ix)	Hepatitis-B	Yes <input type="checkbox"/>	No <input type="checkbox"/>
(x)	Epilepsy	Yes <input type="checkbox"/>	No <input type="checkbox"/>
(xi)	Nervous disorder	Yes <input type="checkbox"/>	No <input type="checkbox"/>
(xii)	Liver	Yes <input type="checkbox"/>	No <input type="checkbox"/>
(xiii)	Leprosy	Yes <input type="checkbox"/>	No <input type="checkbox"/>
(xiv)	Any physical deformity or handicap	Yes <input type="checkbox"/>	No <input type="checkbox"/>
(xv)	Any other serious disease	Yes <input type="checkbox"/>	No <input type="checkbox"/>

c. Has any of family members of child (Father, Mother, Brothers or Sisters) living or dead suffered from any hereditary or infectious disease like, Insanity/ Epilepsy/ Gout/ Asthma/ Tuberculosis/ Cancer/ Leprosy etc?

Yes No

If yes, give details: _____

d. Have child hospitalized during the last 3 years? If so, furnish the following information.

	Ailment	Name of Hospital	Period of Hospitalization	
			From	To
1.				
2.				
3.				

e. Does the child any physical deformity or congenital by birth defects? (Yes/ No) _____

i. If yes, Type of deformity (Congenital/ Non-Congenital): _____

ii. In case of congenital deformity, please state whether it is Blindness/ Deafness/ Dumbness/ Orthopedic Handicap of One Limb/ Loss of one limb/ Midgets/ Hunchback _____

iii. In case of non-congenital deformity, please state whether it is Blindness/ Deafness/ Dumbness/ Orthopedic Handicap of One Limb/ Loss of one limb _____

iv. In case of congenital/ non-congenital deformity, please state whether it is Orthopedic Handicap of both Limbs/ Loss of both limbs/ Mentally retarded having mental age of 14 or above/ Weakness or deformity/ Paralysis due to Polio/ Any other deformity of non-neurological origin _____

f. Particulars of the family doctor, if any: _____

9. Declaration of Parent

(A) I do hereby declare that (a) no proposal of insurance on life of above named child has ever been adversely treated by any insurance company (b) the foregoing statements made are true to the best of my knowledge and belief (c) in case it is found that I have wilfully made any untrue statement or have concealed any relevant circumstances then all the premia which shall have been paid by me, shall be forfeited and this contract rendered absolutely null and void (d) I understand that child's life shall be insured from the date my proposal is accepted (e) I have gone through the terms and conditions for insurance with PLI, a copy of which has been given to me and explained to me in my language. I hereby agree to abide by them.

(B) I hereby agree to pay the fee of ₹ _____ (per individual) for the medical examination if our proposal is not accepted.

Parent's Signature: _____

Dated: The _____ Day of _____ 20 _____

10. Certificate of Immediate Superior

Certified that _____ is a permanent/ temporary employee in _____ and information furnished against column No. 1 to 4 of this proposal form is correct as per his/ her service records.

Date : _____

Signature: _____

Place: _____

Name : _____

11. To be filled in by DO/ FO (PLI)/ Agent

I _____ Agent Code No./ ID _____ certify that the information in the proposal form has been furnished by the proponent and it has been signed by him/ his thumb impression has been taken 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: _____

Agent's Signature: _____

12. Medical Examiner's Certificate:

Certified that I have carefully examined Master/ Shri/ Ms. _____ the proponent whose signature is given below today the _____ Day of _____ 20_____.

On careful examination of the proponent and after going through the information furnished by him/ her under column 11, 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 Child: _____

Signature of Medical Examiner: _____

Name: _____

Seal : _____

Date : _____

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.

13. Confidential Report (Applicable only in case of Children Policy under RPLI)

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	<input type="checkbox"/>	No	<input type="checkbox"/>
2.	Are you aware of any financial/physical/mental situation concerning proposer which makes him unsuitable for consideration of his Insurance proposal?	:	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
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	<input type="checkbox"/>	No	<input type="checkbox"/>
4.	Has he signed proposal/Declaration form?	:	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
5.	Any other matter you would like to bring to the notice of Proposal accepting authority.	:	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
6.	Do you recommend the acceptance of the proposal?	:	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
7.	If not recommended, give reasons.	:	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
8.	Please confirm that :-					
	(1) Confidential report has been written by you after completion of proposal form by proposer.	:	Confirmed	<input type="checkbox"/>	Not Confirmed	<input type="checkbox"/>
	(2) Confidential report has not been divulged to proposer/ or discussed with him.	:	Confirmed	<input type="checkbox"/>	Not Confirmed	<input type="checkbox"/>

Signature of SDI/ ASP
Full Name With Stamp

CLAIM FORM FOR MATURITY/SURVIVAL BENEFIT OF PLI/RPLI POLICY

(Please fill in BLOCK letters)

Service Request No. : (For Official only)			
1 Policy Details :			
i	Policy Type:	ii	Policy No. :
iii	Name of Insurant :	iv	Sum Assured :
v	Date of Acceptance : (dd/mm/yyyy)	vi	Premia Frequency (Monthly/Quarterly etc):
vii	Date of Survival Benefit Due : (dd/mm/yyyy) (AEA Policy)		OR Date of Maturity : (dd/mm/yyyy)
viii	Loan taken against policy : <input type="checkbox"/> Yes <input type="checkbox"/> No		
2.	If yes, Loan Sanction Amount :	Date of last Installment of Loan Repayment : (dd/mm/yyyy)	
	Outstanding Loan Amount :		
3.	Missing Credit Premium Details: (in case any premia paid is not included in the Intimation Letter)		
4.	Communication Address :		
	Address :		
	District :	State :	
	PIN Code :	Contact Phone Number :	
	Aadhar Number :	e-Mail ID :	
5.	Name of Spouse (in case of Yugal Suraksha Policy):		
6.	Office Address of DDO (For Pay Recovery Policy only)		
	Name & Designation of DDO:		Name of Organization:
	Office Address:		District & State :
	PIN Code :		Phone no & email id:
7.	Account Details (if payment desired through NEFT/Credit)		
	Bank Account Details		Post Office Saving Bank Account Details
	Account Number:		Account Number:
	Account Type:		Name of Account Holder
	Name of Account Holder:		Post Office Name :
	Name of Bank:		CBS Post Office (Y/N):
	Address or Branch Name:		Pin code/SOL ID

IFSC code:	First page of Pass Book Enclosed (Y/N)
Cancelled Cheque Enclosed (Y/N):	

Documents Enclosed:

Yes/No/ NA(Not Applicable)

1. Original Policy Bond or Letter of Indemnity
2. Self Attested copy of ID proof of the Insurant
3. Self Attested copy of address proof of the Insurant
4. Documents of Credit /Premium Receipt Book (D.O.C. if Pay policy or Premium Receipt Book if Cash Policy and all the paid premium not updated on McCamish Software)
5. Loan Receipt Book (if outstanding loan amount as mentioned in Intimation letter and Loan Receipt book differs)
6. Cancelled Cheque of Insurant Bank Account for Bank Mandate or self attested copy of POSB passbook
7. Self-Attested Copy of ID proof of Messenger (if messenger appointed by Insurant for submission of Maturity claim form)
8. Self-Attested Copy of Address proof of Messenger (if messenger appointed by Insurant for submission of Maturity claim form)
9. Self-Attested medical certificate of insurant from Govt. Hospital/Govt. accredited hospital

Or

self-attested copy of passport clearly showing visa details and date of departure from India In case messenger is appointed
10. Any other document(s), pls specify

Date : _____

Appointment of Messenger

(Required only if Maturity/Survival claim form is being submitted through Messenger)

I hereby declare that I(insurant name), am unable to visit post office, being medically unfit or outside India, for submission of Maturity/survival benefit claim form. I hereby appoint Shri/Smt./Ms. (name of messenger), whose signature is given below, as a messenger for submission of my maturity/survival benefit claim form along with necessary documents.

Signature of Messenger

Name of Messenger

Signature/Thumbprint of Insurant

In case Insurant is illiterate, there should be two literate witnesses-

Witness	Name & Address	Signature
Witness 1		
Witness 2		

For Official Use

Certified that I have checked all the documents enclosed and compared with the original documents produced by the Insurant/messenger and verified the averments made in the Maturity claim form based on these documents and found no discrepancies.

Date:-

Signature of BPM/SPM/PM/ CPC in-Charge

Name :

Designation:

Office Stamp:

Acknowledgement Slip

(To be filled by BPM/SPM/Post Master/CPC in-charge and Handed Over to Insurant)

Maturity/Survival Benefit Claim Form for Policy No. _____ with Service Request No. _____
received onalong with following documents:

Documents Enclosed:

Yes/No/ NA(Not Applicable)

- | | |
|---|--------------------------|
| 1. Original Policy Bond or Letter of Indemnity | <input type="checkbox"/> |
| 2. Self Attested copy of ID proof of the Insurant | <input type="checkbox"/> |
| 3. Self Attested copy of address proof of the Insurant | <input type="checkbox"/> |
| 4. Document(s) of Credit or Premium Receipt Book | <input type="checkbox"/> |
| 5. Loan Receipt Book | <input type="checkbox"/> |
| 6. Cancelled Cheque of Insurant Bank Account for Bank Mandate or self attested copy of POSB passbook | <input type="checkbox"/> |
| 7. Self-Attested Copy of ID proof of Messenger | <input type="checkbox"/> |
| 8. Self-Attested Copy of Address proof of Messenger | <input type="checkbox"/> |
| 9. Self-Attested medical certificate of insurant from Govt. Hospital/Govt accredited hospital
Or
self-attested copy of passport clearly showing visa details and date of departure from India | <input type="checkbox"/> |
| 10. Any other document(s), pls specify | |

Date:-

Signature of BPM/SPM/PM/ CPC in-Charge

Name :

Designation:

Office Stamp:

LETTER OF INDEMNITY**(To be executed by the Insurant in absence of Original Policy document)**

I..... held myself and my family bound to the Department of Posts (hereinafter called India Post), in the sum of (sum assured of the policy) of lawful money to be paid on demand or without demand to India Post, its attorneys, successors or assignees for which I bind myself, my executors, administrators, successors, and representatives, firmly by this declaration.

Whereas on the day of I, Sh./Smt./Ms..... (the policy holder), purchased from India Post, a PLI/RPLI Policy Numbered.....of the sum assured Rs..... bearing a premium of Rs.....per.....(month/quarter/half year/year) payable up to the (month & year) and I have applied to India Post for the settlement of my Maturity claim and payment of money in respect of the said policy AND Whereas the policy has been lost/untraceable and is not forthcoming AND Whereas I have not produced the said policy issued to (name of the Insurant) by India Post AND Whereas I declare that the said policy has not been assigned or transferred to anybody or disposed of in any other way with such consideration as here under is written.

I hereby undertake to refund all the money with interest to India Post in case of wrong information furnished above leading to unjust payment to me.

Provided further that the liability of sureties hereunder shall not be impaired or discharged by reason of time being granted or any forbearance act or omission of India Post or any person authorised by them (whether with or without the consent or knowledge of the sureties) nor shall be necessary for India Post to sue me (Claimant) before suing the sureties for amounts due hereunder.

Signature/Thumb Impression of the Insurant	
Name	
Complete Address	
Mob & email Id	

Signed sealed and delivered by the above

Witness	Name, Address and contact details	Signature
Witness 1		
Witness 2		

Sureties	Name, Address and contact details	Signature
Surety 1		
Surety 2		

Signed sealed and delivered by the above

Witness for Sureties	Name, Address and contact details	Signature
Witness 1		
Witness 2		

Note: Self Attested copy of ID proof and Address proof of all Sureties and Witnesses are to be enclosed with this Letter of Indemnity.

Annex - I**Claim Application Form for PLI/RPLI (Death Cases)**

(Please fill in BLOCK Capitals)

Service Request No. : (For Official Only)			
1 Policy Details :			
i	Policy No. :	ii	Name of Insurant :
iii	Sum Assured :	iv	Date of Acceptance : (dd/mm/yyyy)
v	Date of Survival Benefit Due : (AEA Policy) (dd/mm/yyyy)	vi	Date of Maturity : (dd/mm/yyyy)
vii	Loan taken against policy : <input type="checkbox"/> Yes <input type="checkbox"/> No (if yes please attach Loan Repayment Receipt Book& fill column 2)		
2.	Loan Sanctioned Amount :	Date of Loan Repayment : (dd/mm/yyyy)	
3. Details of Death of Insurant:			
i	Date of Death : (dd/mm/yyyy)	ii	Cause of Death :
iii	Place of Death (Full Address with Pin Code) :		
4.(A) Details of Claimant-1:			
i	Name of Claimant :	ii	Age of Claimant *: (if Claimant is minor please fill column 5)
iii	Relationship of Claimant with Insurant:	iv	Proof of Relationship ** :
v	Address:		
	District :	State :	
	PIN Code :	Mobile No :	
	e-Mail ID :	Share of Claim amount (%) :	
4.(B) Details of Claimant-2 (if Claimant is more than one):			
i	Name of Claimant:	ii	Age of Claimant *: (if Claimant is minor please fill column 5)
iii	Relationship of Claimant with Insurant:	iv	Proof of Relationship ** :
v	Address:		
	District :	State :	
	PIN Code :	Mobile No :	

	e-Mail ID :	Share of Claim amount (%) :	
4.(C)	Details of Claimant-3 (if Claimant is more than one):		
i	Name of Claimant :	ii	Age of Claimant *: (if Claimant is minor please fill column 5)
iii	Relationship of Claimant with Insured :	iv	Proof of Relationship ** :
v	Address:		
	District :	State :	
	PIN Code :	Mobile No :	
	e-Mail ID :	Share of Claim amount (%) :	
5. (A)	To be filled If Claimant is a minor (A) if minor Claimant is more than one:		
i	Name of Guardian/ Appointee :	ii	Relationship with minor claimant :
iii	Is Father of minor claimant deceased (Y/N):	iv	Is Mother of minor claimant deceased (Y/N):
5. (B)	To be filled If Claimant is a minor (B) if minor Claimant is more than one:		
i	Name of Guardian/ Appointee :	ii	Relationship with minor claimant :
iii	Is Father of minor claimant deceased (Y/N):	iv	Is Mother of minor claimant deceased (Y/N):
v	<p>If you are not father or mother of the minor claimant, have you been appointed guardian of the minor claimant by nomination or under any enactment in force in India? Please state and produce document in support of your claim</p> <p>(Claimant A) _____</p> <p>(Claimant B) _____</p>		
vi	Does the minor claimant resides with you : (Yes/No)	vii	Is the minor maintained by you (Yes/No) :
6.	Account Details (if payment desired through Bank Mandate)		
	<input type="checkbox"/> Post Office <input type="checkbox"/> Bank	Account No. :	
	Name of Account Holder:		
	Name of Post Office/Bank:	Branch:	
	IFSC code:	Cancelled Cheque Enclosed (Y/N):	

(*) Age of Claimant in completed years.

(**) Provide any valid document for proof of relationship between Insurant and Claimant.

Documents Enclosed:

Yes/No/ NA(Not Applicable)

- 1. Original Policy Bond or Letter of Indemnity (Format at Annex III)
- 2. Self Attested copy of Death Certificate (issued by Local Administration/register of local board/village panchayat/Medical Practitioner or Certificate of Doctor, who last attended the insurer clearly mentioning reason of death)
- 3. Self Attested copy of Succession Cert./Letter of Administration/Probate of Will, if nomination is not available
- 4. Self Attested copy of ID proof of the Claimant(s)
- 5. Self Attested copy of address proof of the Claimant(s)
- 6. Self Attested copy of FIR (in case of unnatural death of Insurant)
- 7. Self Attested Post-mortem report (in case of unnatural death of Insurant)
- 8. Cancelled Cheque of Claimant(s)'s Bank Account(s) for Bank Mandate
- 9. Documents of Credit or Premium Receipt Book (D.O.C. if Pay policy or Premium Receipt Book if Cash Policy and all the paid premium not updated on McCamish Software)
- 10. Loan Receipt Book (if Loan taken on Policy)
- 11. Indemnity Bond (in case of Unanatural death)
- 12. Any other document(s), pls specify

Date: _____

Signature/Thumbprint of Claimant/Guardian of Claimant

In case Claimant/Guardian of Claimant is illiterate, there should be two literate witnesses-

Witness	Name & Address	Signature
Witness 1		
Witness 2		

For Official Use

Certified that I have checked all the documents enclosed and compared with the original document produced by the claimant and verified the averments made in the claim form based on these documents and found no discrepancies.

Date:-

**Signature of BPM/SPM/PM/ CPC in-Charge
Name :
Designation:
Office Stamp:**

Acknowledgement Slip

(To be filled by BPM/SPM/Post Master/CPC in-charge and Handed Over to Claimant)

Claim Application for Policy No. _____ received on _____ with Service Request No. _____ and following documents are received from the Claimant:

Documents Received:	Yes/No/ NA (Not Applicable)
1. Original Policy Bond or Letter of Indemnity	<input type="checkbox"/>
2. Self Attested copy of Death Certificate (issued by Local Administration/register of local board/village panchayat/Medical Practitioner or Certificate from Doctor who last attended the insurer clearly mentioning reason of death)	<input type="checkbox"/>
3. Self Attested copy of Succession Cert./Letter of Administration/Probate of Will if nomination is not available	<input type="checkbox"/>
4. Self Attested copy of ID proof of the Claimant(s)	<input type="checkbox"/>
5. Self Attested copy of address proof of the Claimant(s)	<input type="checkbox"/>
6. Self Attested copy of FIR (in case of unnatural death of Insurant)	<input type="checkbox"/>
7. Self Attested Post-mortem report (in case of unnatural death of Insurant)	<input type="checkbox"/>
8. Cancelled Cheque of Claimant(s)'s Bank Account(s) for Bank Mandate	<input type="checkbox"/>
9. Documents of Credit or Premium Receipt Book (D.O.C. if Pay policy or Premium Receipt Book if Cash Policy and all the paid premium not updated on McCamish Software)	<input type="checkbox"/>
10. Loan Receipt Book (if Loan taken on Policy)	<input type="checkbox"/>
11. Indemnity Bond (in case of Unantural death)	<input type="checkbox"/>
12. Any other document(s), pls specify	<input type="checkbox"/>

Date:-

Signature of BPM/SPM/PM/ CPC in-Charge
Name :
Designation:
Office Stamp:

LETTER OF INDEMNITY**(To be executed by the Claimant in absence of Original Policy document)**

I..... held myself and my family bound to the Department of Posts (hereinafter called India Post), in the sum of (sum assured of the policy) of lawful money to be paid on demand or without demand to India Post, its attorneys, successors or assignees for which I bind myself, my executors, administrators, successors, and representatives, firmly by this declaration.

Whereas on the day of Sh./Smt./Ms..... (the policy holder), purchased from India Post, a PLI/RPLI Policy Numbered.....of the sum assured Rs..... bearing a premium of Rs.....per.....(month/quarter/half year/year) payable up to the (month & year) in his/her name AND Whereas I, as the nominee/legal heir have applied to India Post for the settlement of my claim and payment of money in respect of the said policy AND Whereas the policy has been lost and is not forth-coming AND Whereas I have not produced the said policy issued to (name of the Insurant) by India Post AND Whereas I declare that the said policy has not been assigned or transferred to anybody or disposed of in any other way with such consideration as here under is written.

I hereby undertake to refund all the money with interest to India Post in case of wrong information furnished above leading to unjust payment to me.

Provided further that the liability of sureties hereunder shall not be impaired or discharged by reason of time being granted or any forbearance act or omission of India Post or any person authorised by them (whether with or without the consent or knowledge of the sureties) nor shall be necessary for India Post to sue me (Claimant) before suing the sureties for amounts due hereunder.

Signature/Thumb Impression of the Claimant	
Name	
Complete Address	
Mob & email Id	

Signed sealed and delivered by the above

Witness	Name, Address and contact details	Signature
Witness 1		
Witness 2		

Sureties	Name, Address and contact details	Signature
Surety 1		
Surety 2		

Signed sealed and delivered by the above

Witness for Sureties	Name, Address and contact details	Signature
Witness 1		
Witness 2		

Note: Self Attested copy of ID proof and Address proof of all Sureties and Witnesses are to be enclosed with this Letter of Indemnity.

INDEMNITY BOND**(To be executed by the Claimant in case of Unnatural death of Insurant)**

I..... hereby solemnly affirm and declare that, I am neither involved in nor responsible for, directly or indirectly, death of the Insurant for the policy number for sum assured Rs. I am neither named as suspect/accused nor proposed to be named as suspect/accused by the Police in the death case of the Insurant.

I hereby held myself and my family bound to the Department of Posts (hereinafter called India Post) for the sum of (sum assured of the policy) along with bonus amount to be paid on demand or without demand to India Post, its attorneys, successors or assigns or representatives for which I bind myself, my executors, administrators, successors, and representatives, firmly by this declaration.

I hereby undertake to refund all the money (sum assured along with bonus amount paid) with interest to India Post in case of wrong information furnished above or in case I am later convicted by the Court of Law in the death case of the Insurant.

Provided further that the liability of sureties hereunder shall not be impaired or discharged by reason of time being granted or any forbearance act or omission of India Post or any person authorised by them (whether with or without the consent or knowledge of the sureties) nor shall be necessary for India Post to sue me (Claimant) before suing the sureties for amounts due hereunder.

Signature/Thumb Impression of the Claimant	
Name	
Complete Address	
Mob & email Id	

Signed sealed and delivered by the above

Witness	Name, Address and contact details	Signature
---------	-----------------------------------	-----------

Witness 1		
Witness 2		

Sureties	Name, Address and contact details	Signature
Surety 1		
Surety 2		

Signed sealed and delivered by the above

Witness for Sureties	Name, Address and contact details	Signature
Witness 1		
Witness 2		

Note: Self Attested copy of ID proof and Address proof of all Sureties and Witnesses are to be enclosed with this Indemnity Bond.

APPLICATION FOR LOAN ON SECURITY OF PLI/RPLI POLICY

(Please fill in BLOCK letters)



Service Request No. : (For Official only)			
1 Policy Details (particular of policy against which the loan is desired):			
i	Policy No. :	ii	Name of Insurant :
			Name of Spouse (in case of Yugal Suraksha Policy) :
iii	Sum Assured :	iv	Date of Acceptance : (dd/mm/yyyy)
v	Date of Maturity: (dd/mm/yyyy)	vi	Amount of Loan required :
vii	Purpose for which Loan is required :		
2. Details of Previous Loan taken on this Policy (if any)			
i	Amount of Previous Loan :	ii	Sanction No.:
iii	Sanction Date:	iv	Date of final repayment of previous Loan:
3. Missing Credit Premium Details (Please enclose supporting documents):			
4. Communication Address :			
Address :			
District :		State :	
PIN Code :		Contact Phone Number :	
Aadhar Number :		e-Mail ID :	
5. Office Address of DDO (For Pay Recovery Policy only)			
Name & Designation of DDO :		Name of Organization :	
Office Address :		District & State :	
PIN Code :		Phone No. & e-Mail ID :	
6. Account Details (if payment desired through NEFT/RTGS/Other Credit)			
Bank Account Details		OR	Post Office Saving Bank Account Details
Account Number:			Account Number:
Account Type:			Name of Account Holder
Name of Account Holder:			Post Office Name :
Name of Bank:			CBS Post Office (Y/N):
Branch Name:			Pin code/SOL ID
IFSC code:			First page of Pass Book Enclosed (Y/N)
Cancelled Cheque Enclosed (Y/N):			

7. Assignment prescribed under Rule 31 of Estate Duty Rules, 1953, in respect of PLI/RPLI Policies assigned to the President for the purpose of paying Estate Duty:

"I do hereby assign the benefit of all moneys to become payable under the Postal Life Insurance Policy/Rural Postal Life Insurance Policy No..... assuring the sum of(Rs.) to the President of India for the purpose of paying Estate Duty in accordance with the provision contained in clause (f) of sub section (1) of Section 33 of the Estate Duty Act, 1953, which after my death my estate may become liable to pay to the Government of India.

Provided, however, that in the event of my surviving the date on which the said policy if so expressed would mature or the policy is surrendered by me, the benefit of the policy and the right to receive moneys there under shall revert to me as if this assignment had not been made. It is further agreed that if the policy matures before my death or is surrendered by me, then on my request the Insurer will upon the delivery of the policy pay all or so much or the sum due to me as may be specified in such request, to the Government of India under the head "K-Deposits and Advances- deposits bearing interest-other Deposits –Deposits towards payment of Estate Duty" for being treated as deposits of moneys for the purpose of paying estate duty as provided in clause (g) of Section 33 (1) of Estate Duty Act, 1953 and a receipt of the Government of India shall be an effectual discharge to the Insurer for the moneys so paid to them.

I undertake not to deal with the policy in any way so long as the above assignment is operative, except nominating any person to receive the balance of the insurance proceeds, after satisfying the Estate Duty demand.

I, hereby certify that no prior assignment of the within policy or any encumbrance against it exists.

Dated **(Signature/Thumbprint of Insurant)**

Place :

Witness : Name & Address of witness:- (Copy of self attested ID and address proof of witness is enclosed)

8. Appointment of Messenger (if loan application submitted by messenger)*:

I hereby declare that I,(insurant name) am unable to visit post office , being medically unfit or outside India, for submission of loan application. I appoint Shri/Smt./Ms. (Name of messenger) as a messenger for submission of my loan application and request you, please allow him/her for submission of the loan application along with necessary documents.

Name of Messenger

Signature of Messenger

Signature or thumbprint of Insurant

Signature/Thumbprint of Insurant
Yes/No/ NA (Not Applicable)

Documents Enclosed:

- 1 Self Attested copy of Policy Bond
- 2 Document (s) of Credit (if pay policy) } In case, any premia payment is made in addition to the details available in loan quote
- Or
- 2 Premium receipt book (if cash policy) }
- 3 Self Attested copy of ID proof of the Insurant
- 4 Self Attested copy of address proof of the Insurant
- 5 Loan Repayment receipt Book (in case any loan re-payment is made in addition to the detail available in loan quote)
- 6 Cancelled Cheque of Insurant Bank Account for Bank Mandate Or self attested copy of POSB Passbook First Page
- 7 Self-Attested Copy of ID and address proof of Messenger (if messenger appointed by Insurant for submission of Loan application form)
- 8 Self-Attested medical certificate of insurant from Govt. Hospital/Govt. accredited Hospital } for Appointing a messenger
- Or
- 8 Self-Attested copy of passport clearly showing date of departure from India }
- 9 Any other document(s), pls specify

Date: _____

Signature/Thumbprint of Insurant

In case Insurant is illiterate, there should be two literate witnesses-

Witness	Name & Address	Signature
Witness 1		
Witness 2		

For Official Use

Certified that I have checked all the documents enclosed and compared with the original document produced by the Insurant/messenger and verified the averments made in the Loan application based on these documents and found no discrepancies.

Date:-

Signature of BPM/SPM/PM/ CPC in-Charge
Name:
Designation:
Office Stamp:

Acknowledgement Slip

(To be filled by BPM/SPM/Post Master/CPC in-charge and Handed Over to Insurant)

Loan Application for Policy No. _____ received on _____ with Service Request No. _____ and following documents are received from the Insurant:

Documents Enclosed:		Yes/No/ NA (Not Applicable)
1	Self Attested copy of Policy Bond	<input type="checkbox"/>
2	Document (s) of Credit (if pay policy) Or Premium receipt book (if cash policy)	<input type="checkbox"/>
	} In case, any premia payment is made in addition to the details available in loan quote	
3	Self Attested copy of ID proof of the Insurant	<input type="checkbox"/>
4	Self Attested copy of address proof of the Insurant	<input type="checkbox"/>
5	Loan Repayment receipt Book (in case any loan re-payment is made in addition to the detail available in loan quote)	<input type="checkbox"/>
6	Cancelled Cheque of Insurant Bank Account for Bank Mandate Or self attested copy of POSB Passbook First Page	<input type="checkbox"/>
7	Self-Attested Copy of ID and address proof of Messenger (if messenger appointed by Insurant for submission of Loan application form)	<input type="checkbox"/>
8	Self-Attested medical certificate of insurant from Govt. Hospital/Govt. accredited Hospital Or Self-Attested copy of passport clearly showing date of departure from India	<input type="checkbox"/>
	} for Appointing a messenger	
9	Any other document(s), pls specify	

Date:-

Signature of BPM/SPM/PM/ CPC in-Charge

Name :

Designation:

Office Stamp:

Annex - III



(Assignment/Re-assignment Details (if Loan taken from organization other than India Post):

Application for Assignment or Re-assignment (Tick whichever is applicable)

1	Policy Details (particular of policy against which the loan is taken):		
i	Policy No. :	ii	Name of Insurant :
iii	Sum Assured :	iv	Date of Acceptance : (dd/mm/yyyy)
v	Date of Maturity: (dd/mm/yyyy)	vi	Amount of Loan required :
vii	Purpose for which Loan is required Or was taken :		
2	Details of Bank/Financial Institution etc. (from which loan is being taken Or was taken):		
i	Name of Bank/Financial Institution etc.:	ii	Industry Type : Bank/Financial Institution/Capital Market Intermediary/Other
iii	Regulated By: IRDA/RBI/SEBI/Other	iv	Official Address of Bank/Financial Institution etc:
v	Contact No.:	vi	e-Mail ID :
vi	Loan Amount :	xv	Loan Sanction letter No. (Copy attached):
3	Loan Sanction Letter No. & date (copy attached in case of assignment of the policy) : <p style="text-align: center;">Or</p> Loan Repayment letter No. & date (copy attached in case of Re-assignment of the policy) :		

Terms & Conditions (in case of Assignment)

- All future premiums shall be paid by the Assignor (Insurant) of the Insurance policy.
- The assignor (Insurant) shall not exercise or hold any rights pertaining to services of the insurance policy including partial withdrawal/surrender without specific consent of the assignee (Bank/financial institution etc).
- The Assignor (Insurant) with suitable concurrence from the Assignee (Bank/financial institution etc) shall intimate India Post about its loan closure for suitable reassignment of the insurance policy to the Assignor (Insurant).

4(A)

Declaration (in case of assignment)

<p>This is to put on record that Shri/Smt./Ms (Name of insurant) is taking loan of Rs.....from (Bank/Financial Institution etc name) for (purpose) in terms of the Loan agreement dated</p> <p>I/We hereby declare that receipt of benefits arising under the policy by the Assignee (Bank/financial institution etc), shall be valid for sufficient discharge of the said loan. Policy servicing requests, as applied to the Policy prior to this Assignment, would continue unless specific instructions are provided to the Bank/Financial Institution etc by both the Assignor and the Assignee. I had by recognized the assignee (Bank/Financial Institution etc) as the only person entitled to the benefit under the policy until the policy is re-assigned.</p> <p>I/We do hereby declare that I/we have read and understood the Terms & Conditions mentioned herein above and agree to abide by the same.</p> <p>Date:</p> <p>Place:</p> <p style="text-align: center;">Signature of Assignor (Insurant) Signature of Assignee with stamp</p>

4 (B)

Declaration (in case of re-assignment)

<p>This is to put on record that Shri/Smt./Ms (Name of insurant) to whom (Bank/Financial Institution etc name) had been granted a Loan of Rs..... for(purpose) in terms of the Loan agreement dated and has/have since repaid the same in full with all dues and that no amount is now due from him/her towards or in respect of the said loan.</p> <p>In view of the above (Bank/Financial Institution etc name) has no claim right, title or interest in respect of PLI/RPLI Policy.</p> <p>I/We do hereby declare that I/we have read and understood the Terms & Conditions mentioned herein above and agree to abide by the same.</p> <p>Date:</p> <p>Place:</p> <p style="text-align: center;">Signature of Assignor with stamp Signature of Assignee (Insurant)</p>
--



Request for Registration/ Change of Nomination in respect of PLI/ RPLI Policy

(refer Section 39 of Insurance act 1938) (Not applicable in case of policy under MWPA 1874)

(Please fill in the columns in CAPITAL letters)

1. Name of Insurant (Mr./ Mrs./ Ms.)

First Name	Middle Name	Last Name

2. Occupation

--

3. Communication Address

Village		Taluka	
City		District	
State		Country	PIN

4. Particulars of Policy:

i. Policy No.

--

ii. Policy Type

--

iii. Sum Assured

₹		/	-
---	--	---	---

iv. Date of Acceptance

	/		/	
--	---	--	---	--

v. Premium Ceasing Age

	Years
--	-------

5. 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:

--

 Share %age:

	%
--	---

 Gender: M F

Date of Birth:

	/		/	
--	---	--	---	--

 Age:

	Years
--	-------

Communication Address

Village		Taluka	
City		District	
State		Country	PIN

Phone No.

--

E-mail ID (If any)

--

ii. Second First Nominee Details- (Mr./ Mrs./ Ms.)

First Name	Middle Name	Last Name

Relationship:

--

 Share %age:

	%
--	---

 Gender: M F

Date of Birth:

	/		/	
--	---	--	---	--

 Age:

	Years
--	-------

Communication Address

Village		Taluka	
City		District	
State		Country	PIN

Phone No.

--

E-mail ID (If any)

--

iii. Third Nominee Details- (Mr./ Mrs./ Ms.)

First Name	Middle Name	Last Name

Relationship: Share %age: % Gender: M F

Date of Birth: / / Age: Years

Communication Address

Village	Taluka
City	District
State	Country
	PIN

Phone No. E-mail ID (If any)

b. Appointee Details (If nominee is minor)

First Name	Middle Name	Last Name

Relationship: Gender: M F

Date of Birth: / / Age: Years

Communication Address

Village	Taluka
City	District
State	Country
	PIN

Phone No. E-mail ID (If any)

Date: _____

Signature of Insurant

Name:.....
 Phone no.:
 Office:.....
 Residence:
 Mobile no.:

Signature of Witness 1:

Name:.....
 Phone no.:
 Office:.....
 Residence:
 Mobile no.:

Signature of Witness 2:

Name:.....
 Phone no.:
 Office:.....
 Residence:
 Mobile no.:

ECS Mandate Form

Postal Life insurance of India

1 Name of the Policy Holder-----

2 Policy Details :

S.NO.	New proposal/Policy number	Name of Insured

3 Contact information

- a Residence -----
b Office -----
c Mobile -----
d Email ID -----

4 Particulars of Bank AC(Account from which you want to pay the premium)

- a Bank Name -----
b Branch Name & Address -----
c Name of account holder -----

d Account Type(Saving/Current/Cash or Credit) -----
e Account Number -----
f 9 Digit MICR CODE Number of the bank and branch -----
(Attach a photocopy/Cancelled cheque leaf) -----

5 I/We agree that this Mandate will form an integral part of my/our proposal (Only for new proposals)

(2) If in future my/our Bank Account is transferred to a city where ECS facility is not available, a change of mode will be necessary which will involve change in premium.

(3) I / We hereby instruct the bank to debit my/our above Account No. and pay PLIPremium of Rs. _____ as above/as per demand sent by PLI.

I/we, hereby, declare that the particulars given above are correct and complete. I/we being the holder/s of the above policy/policies express my/our willingness to remit the premium/s referred to above through participation in ECS of National Clearing Cell of Reserve Bank of India and hereby authorise the Life Insurance Corporation of India to raise the debits on my/our Bank Account towards the said premium/s due referred above. If any transaction is delayed or not effected at all for the reasons of incomplete or incorrect information or non-availability of funds or closure of Accounts etc. I would not hold PLI or the user institution responsible. I understand that the first transaction after authorization may take one month time in getting the process commenced. I also understand that I can pay the premium only on behalf of my near relatives as prescribed by the Income-Tax Act, 1961.

PLACE

Date

Signature of Policy Holder

Signature of Account Holder

