ग्रामीण डाक जीवन बीमा
Rural Postal Life Insurance

Affix here your recent passport

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

(All entries should be filled in CAPITAL letters)

Agent/Advisor Code: KLDA0000

Agent/Sales person Name: NAME OF AGENT Group Leader Name &Code: _____

Proposal Date: 01/09/2020 Date of Declaration: 01/09/2020

Product/ Policy Type: ☐WLA ☐CWLA ☑EA ☐AEA ☐GY

Do you already have any PLI/RPLI policy: Yes / No

Customer ID _____ (for existing custom

1. Proposer's Details:

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

First Name	Middle Name	Last Name
ARUNA	S	AJITH

ii. Aadhaar No. 999999999999 **(optional)** iv. PAN _____ **(optional)**

iii. ☑Father's Name **OR** ☐ Mother's Name

First Name	Middle Name	Last Name
AJITH KUMAR		

iv. Gender ☐ M ☑ F ☐ Others

v. Date of Birth (dd/mm/yyyy) 01/01/1995

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. **FORFEMALE PROPONENT ONLY**

Number of Children	Are you Pregnant now?				If pregnant, expected month of delivery
01	Yes		No	☑	

2. Contact Details

iCorrespondence Address

Tick here if permanent address is same ☐ (√)

Correspondence Address:	Permanent Address:
Fill communication address completely (For online payment, email id is mandatory) Village/Locality: _____ Post Office: _____ Taluka/District: _____ State: Pincode: Mobile No: _____ Email address: (if any)	Fill communication address completely as in proof provided. (Tick if same as communication address (For online payment, email id is mandatory) Village/Locality: Post Office: _____ Taluka/District: _____ State: Pincode: Mobile No: _____ Email address: (if any)

3. Proposer's Occupation and Income Details:

Occupation: HOUSE WIFE

PAN No. (if any)	
Monthly Income	5000

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.	ASWIN AK	M	01/01/2016		Son	100	If nominee is minor, provide mobile no of appointee
2.							
3.							

b. Appointee Details (If nominee is minor)

First Name: KIRAN | Middle Name: | Last Name:

Relationship. FATHER Gender M ☐ F ☐

Date of Birth 01/01/1999

Mobile No. 9999999999

C. Particulars of beneficiary(ies), if policy is taken under Married Women Property Act 1874, (nomination in such cases are not allowed).

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5. Additional Policy Details, if any:

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

Sl. No.	Policy No.	Type	PLI/RPLI/Others	Sum Assured (in ₹)	Maturity Date
1	Provide additional policy details, if any				
2					
3					
4					
			Total: (in ₹)		

*Present aggregated sum assured limit for RPLI Policies is Rs.10,00,000/- (including the existing proposal) and aggregated sum assured limit for PLI/RPLI Policies both is Rs.50,00,000/-.

6. Coverage Details

i. Age at Maturity/ Premium ceasing age: 50 Years | ii. Policy Term: 24 Years | iii. Sum Assured: ₹ 10000000

7. Premium Details

3344+ 60(tax) 3404

Better to wirte calculation

i. Premium: ₹ 3344/- | ii. Initial Premium Payment Mode: CASH (Cash/Cheque/Credit Card/Debit Card) | iii. Subsequent Premium Payment Mode **Cash / Online**: CASH

iv. Premium Payment Frequency: Monthly ☑ Quarterly ☐ Half Yearly ☐ Yearly ☐

8. Proponent's Health Information

a. Are you in sound health at present? **Yes** ☑ **No** ☐

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

			YES	NO
(i)	High blood pressure, angina, heart attack, stroke or any other disorder of heart or circulation?	:		✓
(ii)	Diabetes, Kidney or liver problem?	:		✓
(iii)	Colitis or any other stomach, bowel or bladder growth?	:		✓
(iv)	Asthma, bronchitis, pneumonia, TB or any other respiratory or lung disorder?	:		✓
(v)	Ulcer, chronic diarrhea, hepatitis or jaundice?	:		✓
(vi)	Congenital disorder, anaemia, bleeding or blood disorder?	:		✓
(vii)	Disorder of Skin or Lymph glands?	:		✓
(viii)	Mental or nervous illness (including depression) lasting for more than 3 months and/or requiring more than 10 consecutive days off work?	:		✓
(ix)	Reproductive organ or prostrate disorder?	:		✓
(x)	Arthritis, gout or joint pain, muscle, bone fracture or disorder?	:		✓
(xi)	AIDS OR AIDS related complication or test indicating presence of HIV?	:		✓
(xii)	Any form of cancer, tumour or growth?			✓
(xiii)	Any other illness, surgery or inquiry?	:		✓
(xiv)	Any physical deformity or handicap?	:		✓
(xv)	Epilepsy	:		✓
(xvi)	Paralysis	:		✓

c. Have you ever been hospitalized during the last 3 years? If so, furnish the following information. NO

Sl. No.	Name of Hospital	Period of Hospitalization	Reason for hospitalization
1.			
2.			
3.			

d. Do you have any physical deformity or congenital by birth defects? : **Yes** ☐ **No** ☑

If Yes, please provide details below:

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9. Declaration of Proponent

I ARUNA S AJITH 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 thesame.
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-sixmonths.
c) On surrender, the policy shall attract proportionate bonus on reduced sum assured up to the date for which premium has been paid.However,nobonusshallbepayablebeforecompletionof5yearsofthepolicy.
d) Thediscontinuedpolicyshallnotattractbonuswitheffectfromthedatefromwhichthepremiumisdiscontinued.
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 bepaid.
f) The surrender value shall be calculated by multiplying the sum of reduced sum assured plus the proportionate bonus, if any, withthesurrenderfactorasapplicableontheattainedageonthedateofsurrenderofthepolicy.
g)

I ARUNA S AJITH Son/ Wife/ Daughter of KIRAN aged 26 years do hereby declare that:

i. I ARUNA S AJITH am not suffering from Hypertension & Diabetes and not taking any treatment for Hypertension & Diabetes.

OR (Select/Strike accordingly)

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.

I_____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 byme. 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)

SIGNATURE OF PROPONENT

Dated: 0 1 / 0 9 / 2 0 2 0

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.

(Need to fill this part only if the form is filled by person other than proposer)

Signature:

Declarant's Name: _____

Address: _____

_____

Date: d d / m m / y y y y

11.Declaration by Agent/Sales Person

I Name of agent/salesperson AgentCode No./ID KLDA0000 working asin_____

___BO/SOunderDivision 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 awareaboutfinancial/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: 0 1 / 0 9 / 2 0 2 0

Signature with Stamp:

(Signature of agent)

(Stamp with Name, Agent Code and mobile no. is prefered

Mobile Number: -Mobile no. of agent/salesperson

Email Id: -mail id of agent, if any

11. Medical Examiner's Certificate

Certified that I have carefully examined Shri/Smt. _____ the proponent, whose signature/thumb impression 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 8 &9, 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 their proposal of Postal Life Insurance policy.

OR

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

*SIGNATURE OF PROPONENT

Signature of Proponent: _____

Signature of Medical Examiner:

Name: _____

Seal:

Date: d d / m m / y y y y

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 under weight 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.

FOR OFFICIAL USE ONLY

Proposal No.	Date of Receipt
No. of LI-7(a)	Amount Deposited
Policy No.	
PLI Proposal Receipt No.	Premium: _____ GST: _____

PASTE INDEXING RECIEPT HERE

Paste Receipt Here

Check list cum ConfidentialReport by RPLI sales person/Agent

RPLI salesperson/Agents procuring RPLI policy will carefully check & verify the following documents before completing the Confidential Report in respect of each RPLI proposal:

i. Age proof (self-attested/thumb impressed copy of any of the following documents

I. Standard Age proof (any of the following documents)

a. Birth Certificate
b. School Certificate/Mark sheet
c. PAN Card
d. Passport
e. Driving License

II. Non-Standard Age Proof (any of the following documents)

a. Aadhar Card
b. Elder's declaration
c. Medical Examiner's approximate age certificate
d. Declaration by insurant counter signed by Panchayat Member
e. Voter ID

ii. **Address/Identity Proof (any of the following documents)**

a. Aadhar Card
b. Passport
c. Driving License
d. Ration Card
e. Electricity Bill/Water Bill

Confidential Report(to be completed by the RPLI Agent/Salesperson)

(This will consist of information not revealed in the proposal form. This will be completed by RPLI Agent procuring policy after proposal form is completed by proposer. Content of the record should not be discussed with the proposer or divulged to him.)

1. Are you related to the proposer?	:	Yes	☐	No	☑
2. Are you aware of any financial/physical/mental situation concerning proposer which makes him unsuitable for consideration of his Insurance proposal?	:	Yes	☑	No	☐
3. In case of any doubt, please visit the concerned police station/village sarpanch and verify if the proponent was ever arrested/convicted in the criminal case. If yes, give details.	:				
4. Has he signed/impressed the proposal/Declaration form?	:	Yes	☑	No	☐
5. Any other matter you would like to bring to the notice of Proposal accepting authority.	:	Yes	☐	No	☑
6. Do you recommend the acceptance of the proposal?	:	Yes	☑	No	☐
7. If not recommended, give reasons.					
8. Have you correctly verified & checked Age proof (Non-standard) produced by proposer	:	Yes	☑	No	☐
9.Have you inquired about general health condition of the proposer and confirm that he/she is not suffering from any serious/terminal illness.	:	Yes	☑	No	☐
10.Has the required medical tests/ examination of the proposer been carried out by authorised medical examiner and is found fir/unfit	:	Yes	☑	No	☐
11. Please confirm that: - (1) Confidential report has been written by you after completion of proposal form by proposer.	:	Confirmed	☑	Not Confirmed	☐
(2) Confidential report has not been divulged to proposer/ or discussed with him.	:	Confirmed	☑	Not Confirmed	☐

Signature of RPLI Agent: Signature of agent

Full Name with Agent code No. Name & Agent code (Rubber stamp is prefered)

Mobile No 8888888888 (Mobile no of agent

FORM NO. PLI - 9

POSTAL LIFE INSURANCE
DEPARTMENT OF POSTS

(To be filled in by office)

Agents code KLDA0000 SDI Code

Reference No.

Date 01/09/2020

Office from which received

Medical Examiner's Report

IMPORTANT NOTE

1. PLEASE SATISFY YOURSELF ABOUT THE IDENTITY OF LIFE PROPOSED TO GUARD AGAINST IMPERSONATION. COMPARE IDENTIFICATION MARKS WITH THOSE GIVEN IN PROPOSAL FORM.
2. THIS FORM SHOULD BE ACCOMPANIED BY A PROPOSAL FORM PLI-1 DULY FILLED IN AND SIGNED BY THE PROPOSER.
3. THE PROPOSER SHOULD SIGN IN THE PRESENCE OF MEDICAL EXAMINER AND HIS/HER SIGNATURE SHOULD TALLY WITH SIGNATURES ON PROPOSAL FORM. DO NOT USE THE FORM SIGNED IN ADVANCE.
4. MAKE SUITABLE ENQUIRIES TO ENSURE THAT LIFE PROPOSED HAS DECLARED ALL THE PARTICULARS ABOUT HIS/HER PERSONAL HISTORY OF ILLNESS IN THE PROPOSAL FORM. IF THERE ARE ANY OMISSIONS THE SAME SHOULD BE RECORDED UNDER REMARKS COLUMN OF THIS FORM. REFERENCE MAY BE MADE TO PERSONAL HISTORY STATED IN THE PROPOSAL FORM.

Full Name of the Proposer ARUNA S AJITH

Date of Birth 01/01/1995

Age Next Birthday 26

Occupation Housewife

Identification Marks
(Verify from proposal form)

1. (Two identification marks should be furnished)
2.

Introduced/Identified by

Name Name of agent

Designation Direct Agent/GDS/PA etc....

Signature (Signature of agent)

		REPLIES	Details of Unfavourable Findings
1.	**APPEARANCE**		
(a)	What is his/her apparent age ?	(a) 26	
(b)	Is the general appearance healthy ?	(b) Yes	
(c)	Does the proposer have history of successful vaccination ?	(c) Yes	
(d)	Is there any defect or deformity ?	(d) No	
2.	**MEASUREMENTS AND WEIGHT**		
(a)	Chest (over nipples)	(a)	
(i)	On complete expiration	(i) NA cms.	
(ii)	Full inspiration	(ii) cms.	
(b)	Abdomen (over navel)	(b) cms.	
(c)	Height (without shoes)	(c) cms.	
(d)	Weight (with thin clothes)	(d) cms.	

MOUTH, EYES, EARS AND THROAT

(a) Are the gums, teeth and tongue healthy ? (a) Yes

(b) is there any pyorrhoea ? If so, is it modarate or marked. (b) No

(c) (i) Are there any missing teeth ? if so how many ? (c) (i) No

(ii) For how many missing teeth a denture is worn ? (ii)

(d) Is there any evidence of past or present disease of the eyes, ears, nose or throat ? (if the vision or hearing is affected, give details as indicated alongside) (d) No

If vision affected ascertain power of lenses

Right eye ——— Left eye ———

Does vision appear well corrected with lenses ?

If hearing affected, state degree

Right ear

Left ear

4. Respiratory System

Are there any syptoms or signs suggesting abnormality or disease of the respiratory system ? No

5. Cardiovascular system

(a) (i) is the heart normal in size, position ? (a) (i) Yes

(ii) Are the heart sounds normal ? If murmur is present give its time, extent, point of maximum intensity, conduction. (ii) Yes

(b) (i) State pulse rate ? (ii) Describe abnormalities, if any (b) (i) ——— (ii) ———

(c) Is the condition of blood vessels healthy ? (c) Yes

(d) Blood Pressure : (in supine position with a mercury manometer) (d)

Systolic ——— mm. Hg.

Diastolic ——— mm. Hg.

N. B. : If the Systolic reading is 140 or over, or Diastolic reading is 90 or over a second reading should be taken in supine position after 10 minutes rest.

6. Abdomen

(a) Is there any evidnece of disease or of enlargement of liver or spleen ? If so, state its degree (a)

(b) Is there any lump or tenderness or free fluid or any abnormality in abdomen or any abnormality of pelvis ? (b)

(c) Is there any evidence of piles or fistula ? (c)

NA

7. **Genite-Urinary System**

(a) Urine : (The sample of urine must be pased under such circumstances as to preclude the possiblity of substitution)

(b) If there any evidence of past or present venereal disease ?

(c) Is hernia present ? If so, state side, type, size reducible or not. Whether a properly fitting truss is worn & history of strangulation.

(d) (i) Are the testes normal in location, size and consistency ?

(ii) Is hydrocele present ? If so, state side and give the maximum horizontal circumference of the whole scrotum.

(e) Are there any apparent symptoms of AIDS ? If so, do you recommend an HIV test ?

(a) (i) Sugar _____ (ii) SP Gravity _____
(iii) Albumin _____
(iv) Other Abnormalities _____
(b) _____
(c) _____ **NA**
(d) (i) _____
(ii) _____
(e) _____

8. **Nervous System**

Is there any evidence of nervous disease ? **No**

9. **Operation and other details**

(a) Is there any evidence of any operation, accident or injury ? State the degree of impairment, if any. Give the location, size and condition of scar and nature of operation.

(b) Has he ever undergone any ECG, X-Ray, Screening, Blood, Urine or Stool examination ? If so, ascertain nature of test, date, reason and result.

(c) Is there personal history of

(i) Asthma, bronchitis, tuberculosis or any other disease of lungs ?

(ii) High blood pressure, pain in the chest, or any heart complaint ?

(iii) Diabetes, cancer or tumour of any type ?

(iv) Kidney disease ?

(v) Gastric or duodenal ulcer, colitis or liver trouble ?

(d) Is there any family history of (i) to (v) above.

(e) Has the proposer undergone any H. I. V. test and found positive ?

(a) _____
(b) _____
(c) _____
(i) _____
(ii) _____ **NA**
(iii) _____
(iv) _____
(v) _____
(d) _____
(e) _____

10. **For Female Applicants only**

(a) Is there any Gynaecological problem/Disease ? If so, what type ? (a) _____

(b) Is there any evidence of pregnancy ? (b) _____

11. **GENERAL**

(a) Have you carried out ECG or any other special examination such as heart report etc. alongwith this examination ? If so, give details (a) _____

(b) Do you suspect any adverse feature of past history or habits or existence of any other disease or any other complaint not noted above ? (b) _____

(c) Do you consider the life to be first class ? If not, state the reasons. (c) _____

NA

Space for Additional Remarks

SIGNATURE OF PROPONENT

Signature/thumb impression of the Life proposed Signed in my presence

Signature of the Medical Examiner

I, Dr. _____ hereby certify that I have this day examined the above Life to be assured (whose signatures are attested alongside) personally and have recorded in my own hand the true and correct findings. I declare I am not related to the Life Assured, Agent or Sub Divisional Inspector/ASPOs.

Signature of the Medical Examinor _____

Name (in block letters) _____

Designation _____ Regd. No. _____ State _____

Qualification _____ Code No. _____

Limit of the Examinor (Rs.) _____

Dated _____ on the _____ day of _____ 20____

(Place) (Date) (Month) (Year)