



#### 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.				
<b>Total: (in ₹)</b>				

##### 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.					
<b>Total: (in ₹)</b>					

#### 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 : \_\_\_\_\_

Designation/Seal: \_\_\_\_\_

**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