



Ref. No.: _____

Policy No.: _____

PLEASE FILL UP THE FORM IN BLOCK LETTERS

The company will not be on risk until the proposal has been accepted and full payment of premium has been received.

Policy Issuing Office

| | |
|---|--|
| SM CODE | |
| SM NAME | |
| AGENT / CORPORATE AGENT / BROKER / IMF / CODE | |
| AGENT / CORPORATE AGENT / BROKER / IMF / NAME | |

Please affix Passport size photograph of the Proposer

PROPOSER DETAILS

| Prefix | First Name | Middle Name | Last Name |
|--------------------------------------|---|--|--|
| Proposer Name (same as KYC/ID proof) | | | |
| Father / Spouse Name | | | |
| Mother Name | | | |
| Date of Birth | D D M M Y Y Y Y | Gender | Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender <input type="checkbox"/> |
| Business Type | Do you come under below mentioned Social Sector Classification* | | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| | If Yes (please tick) <input type="checkbox"/> | Unorganized Sector <input type="checkbox"/> Economically Vulnerable or Backward Classes <input type="checkbox"/> Other Categories of Persons <input type="checkbox"/> Informal Sector <input type="checkbox"/> | Rural and Social Sector Classification |
| | | | Are you a ASHA worker <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> |
| | | | Are you a MGNREGA worker <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> |

* "Social Sector" includes unorganised sector, informal sector, economically Vulnerable or backward classes and other categories of persons, both in rural and urban areas; (a) "Unorganised sector" includes self-employed workers such as agricultural labourers, bidi workers, brick kiln workers, carpenters, cobblers, construction workers, fishermen, hamals, handicraft artisans, handloom and khadi workers, lady tailors, leather and tannery workers, papad makers, powerloom workers, physically handicapped self-employed persons, primary milk producers, rickshaw pullers, safaikarmacharis, salt growers, sericulture workers, sugarcane cutters, tendu leaf collectors, toddy tappers, vegetable vendors, washerwomen, working women in hills, daily wagers, hired drivers and coolies or such other categories of persons.(b)"Economically Vulnerable or Backward Classes" means persons who live below the poverty line. (c) "Other Categories of Persons" includes persons with disability as defined in the Persons with Disabilities (Equal Opportunities, Protection of Rights and Full Participation) Act, 1995 and who may not be gainfully employed; and also includes guardians who need insurance to protect spastic persons or persons with disability. (d) "Informal Sector" includes small scale, self-employed workers typically at a low level of organisation and technology, with the primary objective of generating employment and income, with heterogeneous activities like retail trade, transport, repair and maintenance, construction, personal and domestic services and manufacturing, with the work mostly labour intensive, having often unwritten and informal employer-employee relationship.

| | | | |
|---|--|--|--|
| Source of Income | Salaried <input type="checkbox"/> Business <input type="checkbox"/> Others, please specify _____ | Proof of Income to be submitted | IT Returns <input type="checkbox"/> 3mths Payslip <input type="checkbox"/> Other Proof, please specify _____ |
| Annual Income (in Rs.) : | PAN Number [†] _____ | If PAN number is not available submit Form 60 [†] _____ | |
| GST Number | | Residential Status | Indian Resident <input type="checkbox"/> NRI <input type="checkbox"/> PIO <input type="checkbox"/> Foreign National <input type="checkbox"/> |
| CKYC Number | | Email ID | |
| Do you wish to update CKYC with the KYC details provided here | Yes <input type="checkbox"/> No <input type="checkbox"/> | Are you (Proposer) or any of the insured person is a PEP (Politically Exposed Person) or related to PEP ^{‡‡‡} | Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, please provide details _____ |

| | | | |
|-----------------|-----------------------|---|-------------------------|
| Current Address | Address line 1 | Permanent Address (should be same as address Proof) | Address line 1 |
| | Address line 2 | | Address line 2 |
| | City / Town / Village | | City / Town / Village |
| | District | | District |
| | State | | State |
| | Country and Pincode | | Country and Pincode |
| | Mobile Number | | Alternate Mobile Number |

| | | | | | | |
|--|---|----------------------------|--------------------------------------|-------------------|---|--|
| Please attach any one proof in support of ID and Address ^{††} | Voter ID <input type="checkbox"/> | Driving License Exp Dt.: | Aadhar Card <input type="checkbox"/> | Passport Exp Dt.: | NREGA Job Card <input type="checkbox"/> | Any Other Govt. Notified Document <input type="checkbox"/> |
| Nomination | Nominee's Name : | Relationship to Proposer : | Date of Birth | D D M M Y Y Y Y | Age | in yrs |
| | Name of the Appointee (if nominee is a minor) : | Relationship to Nominee : | Date of Birth | D D M M Y Y Y Y | Age | in yrs |

(Incase of Multiple nominees a separate form containing nominee details should be enclosed duly specifying the % to each nominee) Do you wish to receive the copy of the policy document by Email / Whatsapp / Any other electronic mode Yes No

| | | | | | |
|---|--|--|---|------------------------------------|--|
| I would like to receive my insurance policy and all the information related to the proposed insurance policy through insurance repository | Yes <input type="checkbox"/> No <input type="checkbox"/> | If you already have an e-Insurance Account (eIA) number, please provide: | If you don't have an (eIA) number, please choose any one Insurance Repository | Karyv Insurance Repository Limited | CAMS Insurance Repository Services Limited |
| | | | | CDSL Insurance Repository Limited | NSDL National Insurance Repository (NIR) |

| | | | | | | |
|-------------------------------------|---|---------------------|------|-----------------|----|-----------------|
| Please choose the Policy Term Opted | 1 yr <input type="checkbox"/> 2 yrs <input type="checkbox"/> 3 yrs <input type="checkbox"/> | Period of Insurance | From | D D M M Y Y Y Y | To | D D M M Y Y Y Y |
|-------------------------------------|---|---------------------|------|-----------------|----|-----------------|

[†]The copy of PAN card or Form 60 is mandatory | ^{††}If CKYC number is provided, proof of submission is not mandatory | ^{‡‡‡}Politically Exposed Persons (PEPs) are individuals who are or have been entrusted with prominent public functions in a foreign country, example, Heads of State or of Governments, senior politicians, senior government / judicial / military officials, senior executives of state owned corporations, important political party officials, etc., including their family members and close relatives.

STAR HEALTH AND ALLIED INSURANCE COMPANY LIMITED

Regd. & Corporate Office : 1, New Tank Street, Valluvar Kottam High Road, Nungambakkam, Chennai - 600 034. | Phone : 044 - 28288800
Email : support@starhealth.in | Website : www.starhealth.in | CIN : L66010TN2005PLC056649 | IRDAI Regn. No. : 129

| | | | | | | | | | | | | | |
|--|-------------------------------------|---|--|--|--------------------------------------|--|---------------------------------------|--|---|--|-------------------------|--|------------|
| Family Health Optima Accident Care Policy Unique Identification Number: SHAHLIP23170V062223 | | | | Medi Classic Accident Care (Individual) Insurance Policy Unique Identification Number: SHAHLIP23079V062223 | | | | Mode of Payment: <input type="checkbox"/> Cheque <input type="checkbox"/> DD <input type="checkbox"/> Debit Card <input type="checkbox"/> Credit Card <input type="checkbox"/> NEFT <input type="checkbox"/> ECS <input type="checkbox"/> CC Mandate <input type="checkbox"/> Cash (Cash payments are not eligible for the 80D tax benefits) | | | | Premium Amount: _____ Rs. | |
| Applicable for Family Health Optima Accident Care Policy | | | | Applicable for Medi Classic Accident Care (Individual) Insurance Policy | | | | Bank Details of the Proposer | | | | | |
| Sum Insured available under Health Section I | <input type="checkbox"/> 3,00,000/- | <input type="checkbox"/> 10,00,000/- | <input type="checkbox"/> 20,00,000/- | Sum Insured options available under Health Section I | <input type="checkbox"/> 1,50,000/- | <input type="checkbox"/> 4,00,000/- | <input type="checkbox"/> 10,00,000/- | Account Number : _____ | Type of Account | <input type="checkbox"/> Savings Account | | Others Please Specify _____ | |
| | <input type="checkbox"/> 4,00,000/- | <input type="checkbox"/> 15,00,000/- | <input type="checkbox"/> 25,00,000/- | | <input type="checkbox"/> 2,00,000/- | <input type="checkbox"/> 5,00,000/- | <input type="checkbox"/> 15,00,000/- | | | <input type="checkbox"/> Current Account | | | |
| | <input type="checkbox"/> 5,00,000/- | | | | <input type="checkbox"/> 3,00,000/- | <input type="checkbox"/> 10,00,000/- | <input type="checkbox"/> 20,00,000/- | | Name of the Bank : _____ | Payment Details | Cheque / DD No. : _____ | | |
| Family Size: Number of Adults _____ Number of Children _____ Total Number of Members _____ Numbers of Parents / Parent-in-law (as part of the same floater sum insured) _____ | | | Sum Insured options Available in Gold Plan under Section I | <input type="checkbox"/> 3,00,000/- | <input type="checkbox"/> 10,00,000/- | <input type="checkbox"/> 20,00,000/- | Name of the Branch : _____ | Date : <input type="text"/> D <input type="text"/> D <input type="text"/> M <input type="text"/> M <input type="text"/> Y <input type="text"/> Y <input type="text"/> Y <input type="text"/> Y | | | | | |
| | | | | <input type="checkbox"/> 4,00,000/- | <input type="checkbox"/> 15,00,000/- | <input type="checkbox"/> 25,00,000/- | | IFSC Code : _____ | Branch : _____ | | | | |
| **Please check brochure for the available sum insured | | | | Add-on covers available | | <input type="checkbox"/> Hospital Cash | <input type="checkbox"/> Patient Care | | Please attach a photo copy of cancelled cheque leaf | | | | |
| Details of the person/s proposed for insurance | | | | Insured Person - 1 | | Insured Person - 2 | | Insured Person - 3 | | Insured Person - 4 | | Insured Person - 5 | |
| Name | | | | | | | | | | | | | |
| Gender | | Date of Birth | | M / F / Transgender | DD/MM/YYYY | M / F / Transgender | DD/MM/YYYY | M / F / Transgender | DD/MM/YYYY | M / F / Transgender | DD/MM/YYYY | M / F / Transgender | DD/MM/YYYY |
| Height (cms) | | Weight (kgs) | | CMS | KGS | CMS | KGS | CMS | KGS | CMS | KGS | CMS | KGS |
| Relationship with proposer | | | | | | | | | | | | | |
| Occupation | | What is the monthly income from Gainful Employment (in Rs.) | | | | | | | | | | | |
| Ayushman Bharat Health Account (ABHA) No. | | | | | | | | | | | | | |
| Do you want Gold Plan in Section I [Applicable for Medi Classic Accident Care (Individual) Insurance Policy] | | | | <input type="checkbox"/> Yes / <input type="checkbox"/> No | | <input type="checkbox"/> Yes / <input type="checkbox"/> No | | <input type="checkbox"/> Yes / <input type="checkbox"/> No | | <input type="checkbox"/> Yes / <input type="checkbox"/> No | | <input type="checkbox"/> Yes / <input type="checkbox"/> No | |
| Sum Insured Opted (Rs.) in Section I [Applicable for Medi Classic Accident Care (Individual) Insurance Policy] | | | | | | | | | | | | | |
| Do you want Add-ons in Section I [Applicable for Medi Classic Accident Care (Individual) Insurance Policy] - If Yes, Please tick (✓) (Patient Care add-on is available only for Insured Persons above 60yrs of age.) | | | | <input type="checkbox"/> Hospital Cash | | <input type="checkbox"/> Patient Care | | <input type="checkbox"/> Hospital Cash | | <input type="checkbox"/> Patient Care | | <input type="checkbox"/> Hospital Cash | |
| Sum Insured (Rs.) Opted in Section II | | | | | | | | | | | | | |
| Table A | | | | | | | | | | | | | |
| Table B | | | | | | | | | | | | | |
| Table C | | | | | | | | | | | | | |
| Risk Group* (RG) | | | | <input type="checkbox"/> RG - I | | <input type="checkbox"/> RG - II | | <input type="checkbox"/> RG - III | | <input type="checkbox"/> RG - I | | <input type="checkbox"/> RG - II | |
| | | | | <input type="checkbox"/> RG - III | | <input type="checkbox"/> RG - I | | <input type="checkbox"/> RG - II | | <input type="checkbox"/> RG - III | | <input type="checkbox"/> RG - I | |
| | | | | <input type="checkbox"/> RG - II | | <input type="checkbox"/> RG - III | | <input type="checkbox"/> RG - I | | <input type="checkbox"/> RG - II | | <input type="checkbox"/> RG - III | |
| *Risk Group I - Persons engaged primarily in administrative functions. Risk Group II - Persons engaged in manual work other than what is specifically provided for under Risk Group III Risk Group III - Persons working in explosives industry, mine and /or Magazine workers, high tension electric supply, horse racing including jockeys, athletes and occupations of similar hazard | | | | | | | | | | | | | |
| Do you want Optional Benefit / Optional Cover in Section II, If yes please tick the options | | | | <input type="checkbox"/> Medical Exp Ext. | | <input type="checkbox"/> Hospital Cash | | <input type="checkbox"/> Medical Exp Ext. | | <input type="checkbox"/> Hospital Cash | | <input type="checkbox"/> Medical Exp Ext. | |
| | | | | <input type="checkbox"/> Home conv. | | <input type="checkbox"/> Winter Sports | | <input type="checkbox"/> Home conv. | | <input type="checkbox"/> Winter Sports | | <input type="checkbox"/> Home conv. | |
| | | | | <input type="checkbox"/> Winter Sports | | <input type="checkbox"/> Home conv. | | <input type="checkbox"/> Winter Sports | | <input type="checkbox"/> Home conv. | | <input type="checkbox"/> Winter Sports | |
| Existing Insurance Coverage with us and/or any other company give details | | 1. Name of the Insurance Company | | | | | | | | | | | |
| | | 2. Period of Insurance | | | | | | | | | | | |
| | | 3. Sum Insured (Rs) | | | | | | | | | | | |
| | | 4. Policy No. | | | | | | | | | | | |
| Details of Claims | | 1. Ailment for which Claim was made | | Year | | YYYY | | YYYY | | YYYY | | YYYY | |
| | | 2. Claim Amount Paid / Rejected | | | | | | | | | | | |
| Have you ever been declined health insurance coverage due to a diagnosis of a health condition? | | | | | | | | | | | | | |
| Health History: Please provide detailed, response-specific diagnosis and treatment. A mere dash is not sufficient | | | | Family Physician's Name: | | Phone: | | Regn No: | | | | | |
| Note : If any of the below mentioned questions from "1 to 11" is "YES" and if additional space is needed to provide medical condition in detail, please enclose a separate sheet along with this proposal form. | | | | | | | | | | | | | |
| 1. Is the person proposed for insurance in good health free from physical and mental disease or infirmity. If not give details | | | | | | | | | | | | | |
| 2. Has the person proposed for insurance consulted / diagnosed / taken treatment / been admitted for any illness / injury. If yes, give details | | | | | | | | | | | | | |
| 3. Does the person proposed for insurance have any complications during / following birth. If yes, please submit all necessary documents. | | | | | | | | | | | | | |
| 4. Whether the insured person is pregnant if yes, kindly provide duration of pregnancy and scan reports | | | | | | | | | | | | | |
| 5. Has the person proposed for insurance ever suffered or suffering from any of the following | | | | | | | | | | | | | |
| a) Diabetes Mellitus –if yes, mention the duration/date of diagnosis, Type and medication details. | | | | | | | | | | | | | |
| b) High BP/ Cholesterol – if yes, mention duration/date of diagnosis and medication details | | | | | | | | | | | | | |
| c) Thyroid disorders, specify diagnosis Hypo / Hyperthyroid / Autoimmune thyroiditis, Goitre etc), duration/date of diagnosis and medication details | | | | | | | | | | | | | |

| | | | | | |
|--|------|------|---|--|--|
| d) Heart and vascular disease / Arrhythmias / valvular diseases / Cardiomyopathy – if yes, mention duration/date of diagnosis, medication details, Intervention done, CAG, PTCA, CABG and others) | | | | | |
| e) Stroke, epilepsy, fainting attack, chronic headache, Parkinson's disease, Alzheimer's disease, mental disease or infirmity? – if yes, mention the duration/date of diagnosis and medication details | | | | | |
| f) Tuberculosis, asthma, COPD, ILD, other respiratory diseases if yes, mention – duration/date of diagnosis and medication details | | | | | |
| g) Disease of bones/joints, slipped disc, spinal disorder, injury to ligaments – if yes, mention duration/date of diagnosis and operation or treatment details | | | | | |
| h) Whether diagnosed to have arthritis (Rheumatoid / Osteo arthritis or any other inflammatory arthritis like Ankylosing spondylitis). If yes, mention treatment details and submit all records | | | | | |
| i) Gynecological disorder such as menstrual irregularity (DUB), fibroid uterus, ovarian cyst- or have undergone cesarean / hysterectomy – if yes, mention duration/date of diagnosis and medication details | | | | | |
| j) Treatment for sub-fertility or has been advised for? (answer if applicable – if yes, mention duration/date of diagnosis and medication details | | | | | |
| k) Disease of stomach, intestine, liver, gall bladder / Pancreas, Piles / Fistula / Fissure / Hernia if yes, mention duration/date of diagnosis and medication details | | | | | |
| l) Disease of kidney, urinary bladder, urinary tract disease, Calculi- if yes, duration/date of diagnosis and medication details | | | | | |
| m) Disease of prostate / hydrocele / genital disease / - if yes, mention duration/date of diagnosis and medication details | | | | | |
| n) Diseases of the eye, Cataract / corneal / retinal, other disorders and Ear, Nose Throat disease –if yes, mention duration/date of diagnosis and medication details | | | | | |
| o) Cancer, Precancerous lesions, Non-healing ulcers – if yes, mention type of cancer, duration/date of diagnosis and treatment details | | | | | |
| p) Any blood disorder, specify the diagnosis, mention duration/date of diagnosis and medication details | | | | | |
| q) Any autoimmune disease / any long-term steroid / Immunosuppressant intake like myasthenia gravis / SLE / Psoriasis, Ulcerative Colitis, Crohn's disease etc.) duration/date of diagnosis and medication details. | | | | | |
| r) Any other Health problems/diseases please specify | | | | | |
| 6. Has the person proposed for insurance | | | | | |
| a) Undergone any medical test? | | | | | |
| b) Prescribed any medicines? If yes | | | | | |
| 1. Name the illness for which medicines have been prescribed | | | | | |
| 2. Details of medicines and drugs prescribed | | | | | |
| 3. Period for which these drugs were taken | | | | | |
| c) Been advised for any surgery/treatment? – If yes, give details | | | | | |
| d) Received / receiving any payment for any disability / injury / illness / diseases. Give details | | | | | |
| 7. Does the person proposed for insurance has any of the mentioned habits | | | | | |
| a) Chew Tobacco - If yes, since when | | | | | |
| b) Smoke - If yes, since when | | | | | |
| c) Consume Alcohol - If yes, since when | | | | | |
| d) If a, b and c, are mentioned as yes, mandatory to give details whether diagnosed with any local or systemic disease / complications. | | | | | |
| 8. Is the person proposed for insurance positive for HIV, Hepatitis B/C If yes, mention duration/date of diagnosis, medication details, CD4 count (please attach proof) and Viral load | | | | | |
| 9. Type and the total number of medical documents provided | | | | | |
| 10. Does the Insured's Occupation require to engage in manual labour? | | | | | |
| 11. Does the Insured Person engage in or propose to engage in any activity or sport which is hazardous or adventurous in nature such as Racing, Mountaineering, Winter sport etc if so please specify | | | | | |
| Declaration of the Agent / Intermediary : I / We confirm that the product's suitability has been explained to the proposer. The information furnished in the proposal is true to the best of my knowledge and recommend acceptance of the proposal. (Please Enclose Insurance Agent's Confidential Report, If Any) | | | | | |
| | Date | Code | Name of the Agent / Specified Person of Corporate Agent / Broker Qualified Person / Insurance Sales Person of the IMF / | Signature of the Agent / Specified Person of Corporate Agent / Broker Qualified Person / Insurance Sales Person of the IMF | |

STAR HEALTH AND ALLIED INSURANCE COMPANY LIMITED
Acknowledgement

Received the proposal for _____ policy from Mr/ Mrs/ Ms. _____ along with payment of Rs. _____ /- by Cash / vide Cheque/ DD No. _____ dt. _____ drawn on _____. The Cash/Cheque given by you is banked for operational convenience and banking of the Cash/Cheque does not mean acceptance of risk by us. The receipt of the Cash/Cheque will also be acknowledged by our office vide collection receipt. If the proposal is accepted, the cover will commence from the policy start date as stated in the policy schedule, subject to realization of the Cheque. If the proposal is not accepted, the amount paid will be refunded. Contact our office, in case policy is not received within 15 days from the date of payment of premium.

Date: _____ **Place:** _____ **Name & Code of the authorised person:** _____ **Signature of the authorised person:** _____

Proposal Form for Package Products

| | | | | |
|--|--|--|--|--|
| Please affix stamp size photograph of Insured Person - 1 | Please affix stamp size photograph of Insured Person - 2 | Please affix stamp size photograph of Insured Person - 3 | Please affix stamp size photograph of Insured Person - 4 | Please affix stamp size photograph of Insured Person - 5 |
|--|--|--|--|--|

Submitted the above proposal for _____ policy along with payment of Rs. _____ by cash/vide cheque/DD no. _____ dated _____ drawn on _____. I understand that the cash/cheque given is banked for operational convenience and commencement of risk is subject to the acceptance of proposal by you.

Declaration

The primary duty of the proposer is to fill out the proposal form and also to make sure that the proposal contains all the details correctly. If you or any of the insured person(s) have suffered or suffering from any of the diseases which has not been mentioned in the proposal, the claim that may arise will result in a repudiation of the claim/cancellation of the policy.

I/we agree that the PAN details and other information provided by me/us in the proposal form may be used by the Company to download/ verify / modify / add my/our KYC documents from the CERSAI* CKYC portal for processing this application. I/We understand that only the acceptable officially valid documents would be relied upon for processing this application. (*Central Registry of Securitization and Asset Reconstruction and security Interest of India) I hereby consent to receiving information from Central KYC Registry through SMS / email on the above registered number/email address.

1. I hereby declare, on my behalf and on behalf of all persons proposed to be insured, that the above statements, answers and/or particulars given by me are true and complete in all respects to the best of my knowledge and that I am authorized to propose on behalf of these other persons. 2. I understand that the information provided by me will form the basis of the insurance policy, is subject to the Board approved underwriting policy of the insurer and that the policy will come into force only after full payment of the premium chargeable. 3. I further declare that I will notify in writing any change occurring in the occupation or general health of the life to be insured/proposer after the proposal has been submitted but before communication of the risk acceptance by the company. 4. I declare that I consent to the company seeking medical information from any doctor or from a hospital who/which at anytime has attended on the person to be insured/proposer or from any past or present employer concerning anything which affects the physical or mental health of the person to be insured/proposer and seeking information from any insurer to whom an application for insurance on the person to be insured/proposer has been made for the purpose of underwriting the proposal and/or claim settlement. 5. I authorize the company to share information pertaining to my proposal including the medical records of the insured/proposer for the sole purpose of underwriting the proposal and /or claims settlement and with any Governmental and/or Regulatory authority, which includes sharing of my medical data through ABHA. I confirm that the payment is made through my card / bank account. I also confirm that the source of funds for premium paid under this policy is legal. I hereby confirm that the features of the product have been understood by me. I hereby authorize Star Health and Allied Insurance Company to contact me. It will override my registry on the NCPDR.

I would like to contribute in creating a healthier, greener and cleaner environment by receiving my Insurance Policy documents and service related communications only via electronic mode.

| Place | Date | Name | Signature / Thumb impression of the proposer: |
|-------|------|------|---|
| | | | |

WHERE THE PROPOSER IS ILLITERATE OR SIGNS IN A LANGUAGE DIFFERENT FROM THAT OF THE LANGUAGE OF THE PROPOSAL FORM.

| | | |
|--|----------------------------------|---------------------------------------|
| I hereby confirm that the details have been explained to the proposer. | | |
| Date | Name of the person who explained | Signature of the person who explained |

The contents of the proposal form and features of the product have been fully explained to me and I have fully understood the significance of the proposed contract.

| |
|--|
| Signature / Thumb impression of the proposer |
|--|

Prohibition of Rebates: Section 41 of Insurance Act 1938.

1. No person shall allow or offer to allow, either directly or indirectly, as an inducement to any person to take out or renew or continue an insurance in respect of any kind of risk relating to lives or property in India, any rebate of the whole or part of the commission payable or any rebate of the premium shown on the policy, nor shall any person taking out or renewing or continuing a policy accept any rebate, except such rebate as may be allowed in accordance with the published prospectuses or tables of the insurer.
2. Any person making default in complying with the provisions of this section shall be liable for a penalty which may extend to ten lakh rupees.

Beware of spurious phone calls and fictitious/fraudulent offers and never respond to calls/emails/embedded links in SMS/emails asking you to update User id/Password/Credit Card Number/CVV/OTP etc. Insurance is a contract of the utmost good faith, requiring the insured to answer all of the questions on the proposal form honestly and without omitting any information that is relevant. When submitting the proposal form, kindly reveal all pertinent information. If any important information is omitted from the proposal form, personal statement, declaration, or related papers, or if the proposer or someone acting on his behalf makes any false or erroneous statements, misrepresentations, or omissions, the Policy will be invalid, at the insurer's discretion. Please get in touch with the company's offices or agents if you have any questions about the proposal form.