**United India Insurance Company Limited**
Corporate Identity Number: U93090TN1938GOI000108
Registered Office: 24 Whites Road, Chennai – 600014
**IRDAI REG NO.545**

# Spectra Health Insurance Policy

## Proposal Form

### Important Instructions

*Please read the instructions below carefully before filling out this form*

- This Proposal Form shall be the basis of the policy to be issued. Thus, please provide all the information sought in this Proposal Form & all additional relevant information fully & accurately. **Please do not leave any space blank or put dashes.**
- The Company will not be at risk until the Proposal has been accepted by the Company and communication of the acceptance has been given to the proposer in writing after payment of the requisite premium.
- Details of up to 8 Insured Persons, can be filled in this Proposal Form. For additional members, please use a fresh form.
- Pre-policy health check-up reports not older than 30 days must be submitted, wherever required at the Company's discretion.
- A person porting (switching) from a health insurance policy of other non-life insurance or stand-alone health insurance companies must complete Annexure C (Portability Form) along with Proposal Form, Annexure A and B (if required).
- A list of documents required is provided in Annexure D.

### I. Proposer Details

*Please submit a copy of your Proof of Residence as per Annexure D*

Name: .....

Date of Birth: DD/MM/YYYY  Gender: ☐ Male ☐ Female ☐ Other  Marital Status: ☐ Single ☐ Married

Occupation: ☐ Salaried ☐ Self-Employed ☐ Others, please specify .....

PAN: ..... *(Or form 60/61)*  Aadhaar Card/Passport No: .....  E-Insurance Account No.: ..... *(if available)*

Present Address: .....

City: .....  State: .....  Pin Code: .....

Permanent Address: .....

City: .....  State: .....  Pin Code: .....

Tel. No.: .....  Email ID: .....  Mobile: .....

### II. Nomination

*Where the Nominee is a minor, please give the details of the Appointee*

*The nominee mentioned below will be for the 1st Insured. For other members covered under the Policy, the 1st insured is deemed to be the Nominee*

Nominee Name: .....  Nominee Relationship with the Proposer: .....

Present Address: .....

Permanent Address: .....

Bank A/c Number and IFSC: .....  Email ID: .....  Mobile: .....

### III. Coverage Details

*Coverage required from DD/MM/YYYY to midnight of DD/MM/YYYY*

Policy Type: ☐ Individual Sum Insured Basis ☐ Family Floater  TPA preference: .....

Sum Insured Options: ☐ 2 Lakhs ☐ 3 Lakhs ☐ 4 Lakhs ☐ 5 Lakhs ☐ 6 Lakhs ☐ 7 Lakhs ☐ 8 Lakhs ☐ 9 Lakhs ☐ 10 Lakhs ☐ 15 Lakhs ☐ 20 Lakhs ☐ 25 Lakhs

Daily Cash Allowance (Opt.): ☐ Yes ☐ No

### IV. Insured Person(s) Details

*Paste one stamp size photograph and sign below. In case of minor, guardian or proposer may sign*

| *1st Insured Person's Photo* | *2nd Insured Person's Photo* | *3rd Insured Person's Photo* | *4th Insured Person's Photo* | *5th Insured Person's Photo* | *6th Insured Person's Photo* | *7th Insured Person's Photo* | *8th Insured Person's Photo* |
|---|---|---|---|---|---|---|---|
| *Signature* | *Signature* | *Signature* | *Signature* | *Signature* | *Signature* | *Signature* | *Signature* |

| | 1st Insured Person | 2nd Insured Person | 3rd Insured Person | 4th Insured Person | 5th Insured Person | 6th Insured Person | 7th Insured Person | 8th Insured Person |
|---|---|---|---|---|---|---|---|---|
| Name | | | | | | | | |
| Date of Birth | DD/MM/YYYY | DD/MM/YYYY | DD/MM/YYYY | DD/MM/YYYY | DD/MM/YYYY | DD/MM/YYYY | DD/MM/YYYY | DD/MM/YYYY |
| Gender | ☐ M ☐ F ☐ O | ☐ M ☐ F ☐ O | ☐ M ☐ F ☐ O | ☐ M ☐ F ☐ O | ☐ M ☐ F ☐ O | ☐ M ☐ F ☐ O | ☐ M ☐ F ☐ O | ☐ M ☐ F ☐ O |
| Marital Status | ☐ Single ☐ M | ☐ Single ☐ M | ☐ Single ☐ M | ☐ Single ☐ M | ☐ Single ☐ M | ☐ Single ☐ M | ☐ Single ☐ M | ☐ Single ☐ M |
| ABHA ID | | | | | | | | |
| Occupation | | | | | | | | |
| Aadhaar No. | | | | | | | | |
| Sum Insured (if Ind. Basis) | | | | | | | | |
| Height (cm) | | | | | | | | |
| Weight (kg) | | | | | | | | |
| Blood Group | | | | | | | | |
| Relation with the Proposer | | | | | | | | |
| Dependent | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No |

**ABHA Creation Declaration:** I have read the terms of usage of Aadhar for the creation of ABHA Number as available at https://healthid.ndhm.gov.in/register/aadhaar. I consent to the usage of my/our Aadhaar Number(s) by UIIC for the creation of my/our ABHA number(s) through the National Health Authority (NHA). ☐ Yes ☐ No

## V. Existing Health Cover Information

Does any person proposed to be insured presently hold a health insurance policy from any insurer (including UIIC)? ☐ Yes ☐ No

If yes, please give details below.

| | 1st Insured Person | 2nd Insured Person | 3rd Insured Person | 4th Insured Person | 5th Insured Person | 6th Insured Person | 7th Insured Person | 8th Insured Person |
|---|---|---|---|---|---|---|---|---|
| Company | | | | | | | | |
| Policy No. | | | | | | | | |
| Policy Type (Base/ Top-Up) | | | | | | | | |
| Expiry Date | | | | | | | | |
| Sum Insured | | | | | | | | |
| Servicing TPA | | | | | | | | |
| Last Claimed Date | | | | | | | | |
| Claimed Amount | | | | | | | | |
| Porting/Migrating | | | | | | | | |

Kindly fill Annexure C if insured is porting from another insurance company to our company.

Please note that the continuity of benefits shall NOT be considered if the above question is not replied in the affirmative, details are not provided and Portability Form (Annexure C) and relevant supporting documents are not submitted to UIIC.

## VI. Medical Information

**Medical History of the person proposed for Insurance. Tick Yes/No. Please do not leave the spaces blank.**

| | 1st Insured Person | 2nd Insured Person | 3rd Insured Person | 4th Insured Person | 5th Insured Person | 6th Insured Person | 7th Insured Person | 8th Insured Person |
|---|---|---|---|---|---|---|---|---|
| **Lifestyle Questionnaire** Does any person who is proposed for insurance consume | | | | | | | | |
| Alcohol | Y N | Y N | Y N | Y N | Y N | Y N | Y N | Y N |
| Tobacco (Bidi/Cigarette/E- Cigarette/Gutkha/Pan Masala, etc.) | Y N | Y N | Y N | Y N | Y N | Y N | Y N | Y N |

If the answer is 'Yes' to any of the questions above, please give details below on the type and quantity consumed per week and consumption history (years)

- Alcohol –
- Tobacco (Bidi/Cigarette/ E- Cigarette /Gutkha/Pan Masala, etc.) –

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| **Mental Health Questionnaire**<br>Has any person proposed for insurance **ever** faced the following psychological situations? Please provide details in the table below | | | | | | | | |
| Diagnosed with or treated for any psychological or mental health condition? | Y N | Y N | Y N | Y N | Y N | Y N | Y N | Y N |
| Undergone Hospitalisation or Psychological Counselling, or Psychotherapy for any mental health condition? | Y N | Y N | Y N | Y N | Y N | Y N | Y N | Y N |
| **Specific Condition Questionnaire**<br>Has any person proposed for insurance **ever** suffered from/are suffering from any of the following? | | | | | | | | |
| **Cardiovascular System**<br>Heart Diseases (e.g. Coronary Insufficiency, Congenital and Acquired Valvular Diseases, Cardiomyopathy, Congenital Heart Disease)<br>OR<br>Chest Pain, Heart Attack, Angina, Palpitations,<br>OR<br>Undergone Angioplasty/ Bypass Surgery<br>OR<br>Diagnosed with high Blood Pressure (BP) or Hypertension<br>OR<br>Paralysis, or any Blood Clotting disorder | Y N | Y N | Y N | Y N | Y N | Y N | Y N | Y N |
| **Respiratory System**<br>Asthma, COPD, Chronic Bronchitis, Tuberculosis, Pneumonia, Interstitial Lung Disease or any other chronic lung condition | Y N | Y N | Y N | Y N | Y N | Y N | Y N | Y N |
| **Digestive System**<br>Any disorder of the Stomach, Intestines, Liver, Gall Bladder, or Pancreas (e.g., Ulcer, Jaundice, Cirrhosis, Pancreatitis, Hepatitis, Chronic Liver Disease, Piles, Fissures, Fistula, Hernia, etc.) | Y N | Y N | Y N | Y N | Y N | Y N | Y N | Y N |
| **Genitourinary System**<br>Any diseases of the Kidney, Urinary bladder and Urinary tract.<br>OR<br>Any Prostate or Reproductive organ disorder (e.g. DUB, Fibroid uterus, Prolapsed uterus, Ovarian cyst, Benign prostate hypertrophy) | Y N | Y N | Y N | Y N | Y N | Y N | Y N | Y N |
| **Endocrine & Metabolic System**<br>Diabetes (Type I or II) or Prediabetes, Dyslipidaemia, Thyroid-related disorders or any other chronic endocrine and metabolic related disorders. | Y N | Y N | Y N | Y N | Y N | Y N | Y N | Y N |
| **Nervous System**<br>Epilepsy, Seizures, Stroke or Any Neurological disorder (e.g., Parkinson's, Multiple sclerosis, Demyelinating disease, etc.) | Y N | Y N | Y N | Y N | Y N | Y N | Y N | Y N |
| **Musculoskeletal System**<br>Arthritis, Spinal Injury or Deformity, Avascular Necrosis or Fractures or any other Musculoskeletal disease/condition | Y N | Y N | Y N | Y N | Y N | Y N | Y N | Y N |
| **Skin & Connective Tissues**<br>Chronic Skin Conditions (e.g., Psoriasis, Eczema, Vitiligo, etc.) | Y N | Y N | Y N | Y N | Y N | Y N | Y N | Y N |
| **Haematological System**<br>Anaemia of any type, Thalassemia, Haemophilia, Bleeding/ Clotting disorders, or any other Blood condition | Y N | Y N | Y N | Y N | Y N | Y N | Y N | Y N |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| **Immune System / Autoimmune Disorders**<br>Lupus, Rheumatoid Arthritis, Inflammatory Bowel Disease, HIV or any other Autoimmune disease | Y N | Y N | Y N | Y N | Y N | Y N | Y N | Y N |
| **Oncology**<br>Cancer, Tumour, or Any Pre-Cancerous condition | Y N | Y N | Y N | Y N | Y N | Y N | Y N | Y N |
| **Eyes**<br>Any history of Vision loss, Glaucoma, Cataract, ARMD<br>OR<br>Requiring Visual Aids or Surgery<br>OR<br>Any other eye diseases | Y N | Y N | Y N | Y N | Y N | Y N | Y N | Y N |
| **ENT**<br>Any disease of the Ear, Nose or Throat | Y N | Y N | Y N | Y N | Y N | Y N | Y N | Y N |
| **Disability related Questionnaire**<br>Is any person proposed for insurance suffering from any of the following condition/disability? | | | | | | | | |
| Locomotor Disability including Leprosy Cured Person, Acid Attack Victim, Cerebral Palsy, Muscular Dystrophy, and Dwarfism<br>OR<br>Visual Impairment, Hearing Impairment<br>OR<br>Speech and Language Disability<br>OR<br>Autism Spectrum Disorder<br>OR<br>Intellectual Disability (e.g., Down syndrome, Cognitive impairment) | Y N | Y N | Y N | Y N | Y N | Y N | Y N | Y N |
| **General Medical Questionnaire**<br>Does any person who is proposed for insurance ever suffer from/are suffering from any of the following? | | | | | | | | |
| More than two Hospitalization in the previous two years except for hospitalizations for vector-borne, air-borne, and water-borne diseases with hospitalizations less than 5 days.<br>Or<br>Any Surgery/Treatment, consultations, investigations, or diagnostic tests planned or pending | Y N | Y N | Y N | Y N | Y N | Y N | Y N | Y N |
| Experienced pain for more than 7 days in any part of the body<br>OR<br>Restriction of any movement<br>OR<br>Difficulty in swallowing or breathing<br>OR<br>Any difficulty in carrying out your daily activities?<br>Or<br>Persistent headache or cough<br>OR<br>Blood in stool or bleeding from any other orifice/ body opening for more than 5 days? | Y N | Y N | Y N | Y N | Y N | Y N | Y N | Y N |
| Currently taking any prescription medications or undergoing ongoing medical treatments? | Y N | Y N | Y N | Y N | Y N | Y N | Y N | Y N |

If you answered 'Yes' to any of the prior questionnaires, please give details in the following table. Additionally, also submit Annexure A, B.

| Name of the Person to be insured | Illness/Condition | Date of Last Consultation (DD/MM/YYYY) | Medication/ Treatment(s) Undergone and Duration of the Treatment | Name of the treating Doctor | Hospital Name & Phone No. | Present Status |
|---|---|---|---|---|---|---|
| | | | | | | |
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## VII. Past Proposals

Has any proposal for life, health, or critical illness insurance for any of the persons proposed to be insured ever been declined, postponed, loaded, or made subject to any special conditions by any insurance company? If yes, please give the details ☐ Yes ☐ No

## VIII. Bank Details for Processing of Refund

Bank Name: ..... Branch Address: .....

Bank Account No: ..... IFS Code: .....

**Would you like to receive your insurance policy document in physical form, in addition to the electronic copy?** ☐ Yes ☐ No

## IX. Declarations on behalf of all persons proposed to be insured

☐ I hereby declare, on my behalf and on behalf of all persons proposed to be insured, that the statements, answers and/or particulars given by me/us are true and complete in all respects to the best of my knowledge and that I am authorized to propose on their behalf.

☐ 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 United India Insurance Company Limited and that the policy will come into force only after requisite receipt.

☐ I undertake to inform the Company in writing of any change in the occupation or general health of the life to be insured/proposer after the proposal has been submitted but before the communication of the risk acceptance by the company.

☐ I consent and authorize the Company to seek medical information from any doctor, hospital, or past or present employer concerning the health of the insured/proposer and from any insurer to whom an insurance application has been made, for underwriting and/or claim purposes.

.☐ I authorize the company to share information pertaining to my proposal including the medical records of the insured/proposer with TPAs, Service Provider(s) of UIIC, reinsurers and/or any Governmental and/or Regulatory authority solely for underwriting, servicing, claims settlement, fraud detection or compliance with the applicable Law/ Regulations. I consent to United India Insurance Company Limited collecting, processing, storing, verifying, and sharing my/our personal and sensitive personal information, including medical records, strictly for the purposes mentioned above, in accordance with applicable laws, including the Digital Personal Data Protection Act, 2023. I acknowledge that I have been informed about the intended use of such information and provide explicit consent for the same.

☐ I authorize the company to access my/our information as available in my/ our Ayushman Bharat Health Account (ABHA) including the medical records for the sole purpose of proposal underwriting and/or claims settlement and share the same with TPAs, Service Provider(s) of UIIC and/or any Governmental and/or Regulatory authority and/or to comply with the applicable Law/ Regulations.

I also confirm that the source of funds for premium paid under this policy is legal.

Date: DD/MM/YYYY Place: _____ Signature of the Proposer: _____

Name of the Proposer (in BLOCK letters): _____

## X. Certificate from Proposer in case Proposal form is not filled by them/The proposer signs in vernacular language/is illiterate

The proposal form is filled up by my representative, and the contents of the documents have been fully explained to me and I am willing to accept the coverage subject to terms, conditions and exclusions prescribed by the Insurance Company therein.

Date: DD/MM/YYYY Place: _____ Signature of the Proposer: _____

Name of the representative (in BLOCK letters): _____

**Please note that this should necessarily be signed by the proposer and not by his/her representative.**

## XI. Declaration of the Intermediary

I/We confirm that I/We have explained the product features to the proposer and its suitability to him/her and other insured persons.

Date: DD/MM/YYYY Place: _____ Signature of Intermediary: _____

## XII. Statutory Warning (Section 41 of Insurance Act, 1938 – Prohibition of Rebates)

- 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 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 prospectus or tables of the Insurers.
- Any person making default in complying with the provisions of this section shall be punishable with fine which may extend to ten lakh rupees.

## XIII. Office Use Only

Gross Premium: _____ Premium for Optional Cover: _____ Net Premium: _____

Intermediary Code: _____ Development Officer Code: _____

## Acknowledgement by the Company

Date: DD/MM/YYYY

We acknowledge the receipt of your proposal and amount by Cash/Cheque/Others _____ for amount of Rs. _____

**Neither the submission to us of a completed proposal for insurance nor any payment for any policy sought obliges us to agree to issue a policy, which decision is and always shall be in our sole and absolute discretion. If we accept a proposal for insurance, it shall be subject to the policy terms and conditions, and we shall have no liability to make any payment if premium is not received by us in full and in time or is not realized. If we do not accept the proposal, we will inform you and refund any payment received from you without interest within next 30 days.**

***This Annexure is to be completed by EACH insured person who has answered 'Yes' to any of the questions in Section VI (Medical Information) or has any pre-existing conditions/adverse history in respect of any illness.***

Name of Insured Person: .....

## Diabetes Questionnaire

- Date of 1st Diagnosis of Diabetes : .....
- Do you take any anti-diabetic drugs? If so, please give name with dosage : .....
- Please give details of fasting and postprandial blood sugar readings, E.C.G. findings & other investigation reports with date. Please also send reports : .....
- Please state whether you have been diagnosed with any complication of diabetes? : .....

## Hypertension Questionnaire

- Date of 1st Diagnosis of Hypertension : .....
- What is your blood pressure reading? Please state with dates : .....
- Please state names of anti-hypertensive drugs with dosage details : .....
- Are you a smoker? : .....
- Is it essential/secondary/malignant hypertension? : .....
- Please state whether you have been diagnosed with any complication of hypertension? : .....
- Please give findings of all investigation reports : .....

## Chest Pain or Coronary Insufficiency or Myocardial Infarction Questionnaire

- Date of 1st Diagnosis Did you ever suffer from chest pain/coronary insufficiency/myocardial infarction? If so, please give diagnosis and date. : .....
- Please state the name and dose of drugs you are taking at present : .....
- Please state the findings with dates of investigations done like ECG, Stress Test, coronary angiography, X-ray, pathology reports, etc. Please send reports with the proposal form. : .....
- Please state the date of hospitalisation and names of hospitals (attach last discharge summary) : .....
- Please state complications and other related disease, if suffered. : .....
- Please state whether you can do your regular work and whether you have any limitation of activity? : .....
- Are you advised any special treatment? If so, please give information : .....

## Any other Pre-Existing Condition

- Nature of illness/disease/injury & treatment received : .....
- Date of 1st Diagnosis : .....
- Whether fully cured? : .....
- Please state the date of hospitalisation and names of hospitals. (attach last discharge summary) : .....

Date: DD/MM/YYYY Place: ..... Signature of Insured Person: .....

***This Annexure is to be completed by the consulting physician/surgeon if ANY of the insured persons have answered 'Yes' to any of the questions in Section VI (Medical Information) or have any pre-existing conditions/adverse history in respect of any illness.***

- Name of the Insured Person :

**History**

- Present complaints and investigation, if any? :
- Any past history of disease, operations, accidents, investigations with date, major medical complaints of hospitalisation? :
- Details of present and past medication with duration :
- Is he/she cured of diseases, if any? When was your treatment, if any, given, stopped? :
- General Examination :
- Systematic Examination :

**Signature of Consulting Physician** **Signature of Proposer**

**Name of Consulting Physician:** **Place:**

**Qualifications:** **Date:** DD/MM/YYYY

**Address:**

**Telephone No:**

**Office Use Only**

**Do you consider the risk acceptable?**

**Competent Authority:**

**At Operating Office:**

**At Regional Office (If referred to RO):**

***This Annexure is to be completed by the policyholder who is porting from a health insurance policy issued by another insurance company***

Name of Policyholder: .....

Policy No: .....

## PORTABILITY FORM

| | | |
|---|---|---|
| 1. | **Name of the Insured(s)** | |
| 2. | **Date of Birth** | |
| 3. | **Address of the Policyholder** | |
| 4. | **Details of Existing Insurer** | |
| | a. Name of insurance company | |
| | b. Sum Insured | |
| | c. Cumulative Bonus | |
| | d. Add-ons/riders taken | |
| | e. Policy Number | |
| 5. | **Details of the Proposed Insurance** | |
| | a. Name of the product proposed/intended to take | |
| | b. Sum Insured proposed | |
| | c. Whether Cumulative Bonus to be converted to an enhanced sum insured | |
| 6. | **Reason(s) for Portability** | |
| 7. | **No. of family members to be included in the policy to be ported** | |
| **Enclosure: Photocopy of the existing & previous policy documents** | | |
| Date:<br><br>**Signature of the Policyholder** | | |

- Whether the PED exclusions / time bound exclusion have longer exclusion period than the existing policy? (Please indicate Yes / NO):

  .....

- If Yes, please give written consent to the declaration below:

I am aware that the waiting period for the following disease(s)/treatment(s) is more than the previous policy terms. I hereby agree to observe the additional waiting period for the following disease(s)/treatment(s).

| Name of the Disease / Treatment | Waiting Period in Days / Years |
|---|---|
| 1.<br>2.<br>3.<br>4. | |

Date: DD/MM/YYYY Place: ..... Signature of Policyholder: .....

***This Annexure details the list of documents that are required along with this proposal form and the documents that are considered as valid.***

## Documents Required

- Completed Proposal Form
- Cancelled Cheque (supporting bank account details)
- Copy of existing health insurance policies (if applicable)
- Disability Certificate (if applicable)
- Pre-Policy Check-up reports (if applicable)
- Proof of Identity (any one document listed below)
- Proof of Residence (any one document listed below)
- PAN Details (In case PAN not available, Form 60 or 61 as per Rule 114B of the Income-Tax Rule, 1962 must be submitted)
- Stamp Size Photograph (2 no.) for each insured person

## Documentary Proof

| Features | Documents |
|---|---|
| **Proof of Identity** | i. Passport<br>ii. PAN Card<br>iii. Voter's Identity Card<br>iv. Driving License<br>v. Letter from a recognized Public Authority (as defined under Section 2 (h) of the Right to Information Act, 2005) or Public Servant (as defined in Section 2(c) of the 'The Prevention of Corruption Act, 1988') verifying the identity and residence of the customer<br>vi. Aadhaar Card<br>vii. Job card issued by NREGA duly signed by an officer of the State Government |
| **Proof of Residence** | i. Passport<br>ii. Driving License<br>iii. Aadhaar Card<br>iv. Voter's Identity Card<br>v. Job card issued by NREGA duly signed by an officer of the State Government<br>vi. Letter issued by National Population Register containing details of name and address<br><br>Where the above documents do not have the updated address, the following documents shall be deemed to be valid documents for the purpose of Proof of Residence.<br>i. Utility bill which is not more than two months old of any service provider (electricity, telephone, post-paid mobile phone, piped gas, water bill)<br>ii. Property or Municipal Tax receipt<br>iii. Pension or family pension payment orders (PPOs) issued to retired employees by Government Departments or Public Sector Undertakings, if they contain the address<br>iv. Current Photo Passbook with details of permanent/present residence address (updated up to the previous month)<br>v. Current statement of bank account with details of permanent/present residence address (as downloaded)<br>vi. Ration card<br>vii. Valid lease agreement along with rent receipt, which is not more than three months old as a residence proof<br>viii. Employer's certificate as a proof of residence (Certificates of employers who have in place systematic procedures for recruitment along with maintenance of mandatory records of its employees are generally reliable) |
| **Proofs of both Identity and Residence** | Written confirmation from the banks where the proposer is a customer, regarding identification and proof of residence |