Proposal Form No.: MHDI/Health/Retail/OneHealth/003
UIN: MAGHLIP20101V021920

MAGMA HDI
General Insurance Company Ltd.

Magma HDI General Insurance Company Ltd.

OneHealth - Proposal Form

Proposal No._____

1. FOR OFFICE USE ONLY			
Branch Name		Branch Code	
Intermediary Name		Intermediary Code	
Proposal Received On			

GUIDELINES FOR COMPLETION OF THE FORM (TO BE FILLED BY PROPOSER)

Please answer all the questions fully and correctly. This proposal will be the basis of any insurance policy that We may issue. You must disclose all facts relevant to all persons proposed to be insured that may affect Our decision to issue a policy or its price, terms, conditions and exclusions. The policy shall become void at Our sole discretion, in the event of any untrue or incorrect statement, misrepresentation, non-description or non-disclosure in any material particular in the proposal form/personal statement, declaration and connected documents or any material information having been withheld by the Proposer or any one acting on his behalf.

If there is insufficient space for you to provide information whether as requested or otherwise, please attach a separate sheet. If you are in any doubt, please seek the help of Our company representative or your insurance advisor. 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 under the Policy if premium is not received by Us in full and in time, or is not realized or non-fulfillment of pre-policy medical check-up or proposal is not accepted by Us.

All fields/details marked with * are mandatory.

2. PROPOSER DETAILS

Please fill up this form in CAPITAL LETTERS for yourself and each proposed insured person.

Proposer Name* (Mr./Ms./Mrs./Other)				
	(First Name)	(Middle Name)	(Last Name)	
Marital Status	❑ Single	❑ Married		
Gender	❑ Male	❑ Female	❑ None of these	
Nationality*		Date of Birth* (DD MM YYYY)		
Occupation	❑ Salaried	❑ Self-employed	❑ Professional	❑ Others (please specify).....
Annual Income (in ₹)	❑ < 3,00,000	❑ 3,00,000 – 10,00,000	❑ 10,00,001 – 25,00,000	❑ >25,00,000
Address for Correspondence*				
Landmark				
City:	State:		Pin Code:	

Phone No. STD Code **Landline No.** **Mobile No.***

Email ID

Are you a Magma Employee? ❑ Yes, Employee Code..... ❑ No | Do you have any other Policy with Magma HDI? ❑ Yes, Policy No:..... ❑ No

PAN No.# Aadhaar No.

ID Proof Type* ❑ PAN Card ❑ Passport ❑ Voter ID Card ❑ Driving License ❑ Aadhaar Card ❑ Others If others, please specify _____

 # Mandatory if premium under this proposal is Rs. 50,000 or more)

3. PLAN DETAILS*

Policy Type ❑ Individual ❑ Family Floater		**Policy Period**	❑ 1 Year ❑ 2 Years ❑ 3 Years
If Family Floater**, number of persons to be covered: Adults: Children: (**Max 4 Adults and 3 children)*		Premium Payment Frequency	❑ Single Premium ❑ Quarterly Instalment ❑ Monthly Instalment ❑ Semi-annual Instalment

Zone Opted: ❑ Zone 1 (Delhi including National Capital Region, Mumbai including Thane, Navi Mumbai, Vasai-Virar, Bangalore and Gujarat)
❑ Zone 2 (Coimbatore, Pune, Hyderabad, Chandigarh, Chennai, Kolkata and Kerala)
❑ Zone 3 (Rest of India)

Plan	**❑ Support**	**❑ Secure**	**❑ Support Plus**	**❑ Shield**	**❑ Premium** ❑ 10L
Sum Insured (in Lacs)	❑ 2L ❑ 3L	❑ 2L ❑ 3L ❑ 4L	❑ 2L ❑ 3L ❑ 4L	❑ 5L ❑ 7.5L ❑ 10L ❑ 15L	❑ 20L ❑ 30L
	❑ 4L ❑ 5L	❑ 5L ❑ 7.5L ❑ 10L	❑ 5L ❑ 7.5L ❑ 10L	❑ 20L ❑ 25L ❑ 30L ❑ 50L	❑ 40L ❑ 50L ❑ 1Cr
Aggregate Deductible option	❑ Yes ❑ No (If yes, please choose deductible option from below)				

SI	Deductible
❑ 2L ❑ 3L	❑ 1L ❑ 2L ❑ 3L
❑ 4L	❑ 1L ❑ 2L ❑ 3L ❑ 4L
❑ 5L	❑ 1L ❑ 2L ❑ 3L ❑ 4L ❑ 5L
❑ 7.5L	❑ 2L ❑ 3L ❑ 4L ❑ 5L
❑ 10L ❑ 15L ❑ 20L	❑ 2L ❑ 3L ❑ 4L ❑ 5L ❑ 10L
❑ 25L ❑ 30L ❑ 50L	❑ 3L ❑ 4L ❑ 5L ❑ 10L
❑ 1Cr	❑ 5L ❑ 10L

Voluntary Co-Payment ❑ Yes ❑ No (if yes, please choose option from below)
❑ 10% ❑ 20%

4. DETAILS OF INSURED PERSONS TO BE COVERED

Details	Insured Person 1	Insured Person 2	Insured Person 3	Insured Person 4	Insured Person 5	Insured Person 6	Insured Person 7
Title							
Name* (First Name)							
(Middle Name)							
(Last Name)							
Gender (Male/Female/None of these)							
Height* (cm)							
Weight* (kg)							
Eye Refractive Error Index (Left and Right Eye)							
Date of Birth* (DD MM YYYY)		DD MM YYYY	DD MM YYYY	DD MM YYYY	DD MM YYYY	DD MM YYYY	DD MM YYYY
Relationship with Proposer*							
Occupation (Salaried/Self-employed/Professional/Others)							
Optional Cover: Critical Illness Cover (Y/N)	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
Optional Cover: Personal Accident Cover (Y/N)	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N

MAGMA HDI
General Insurance Company Ltd.

5. NOMINATION

Policyholder is the nominee for all Insured members. Below details are for nominee to Policyholder.

Name of Nominee	First	Middle	Last
Relationship with Proposer		Date of Birth (DD MM YYYY)	
Contact Number of Nominee			

If the Nominee is minor, Name and Address of Appointee and Relationship with Minor:

Appointee Name	Relationship with Nominee	Contact Number of Appointee

6. EXISTING/PREVIOUS INSURANCE DETAILS

Is the proposer or the persons proposed, already insured under or proposed for a health insurance policy with Magma HDI General Insurance Company Limited or any other insurance company? ❑ Yes ❑ No

If YES, please indicate below the Policy/Application number(s) (Please mention application number in case of pending proposal.)

Since when are you continuously insured?: DD MM YYYY

Insured Person Name (First, Middle, Last)	Insurer Name	Policy No./ Application No.	Period of Insurance		Sum Insured (₹)	Claims details, if any
			From	To		

If you want to avail the portability benefit from your existing insurance policy, please also submit to us portability form (as an annexure to this proposal form) and all the policy documents relating to the existing policy in addition to the information given above.

7. MEDICAL AND LIFESTYLE INFORMATION*

SECTION A: Have any of the person proposed to be insured ever suffered from/are suffering from any of the following?: Please tick 'YES" for insured person wherever applicable and provide details in Section B.	Insured Person 1	Insured Person 2	Insured Person 3	Insured Person 4	Insured Person 5	Insured Person 6	Insured Person 7
1. Hypertension History (Y/N)							
a) Duration							
b) Medication							
c) Dosage							
2. Diabetes Mellitus History (Y/N)							
a) Type 1 or Type 2							
b) Duration							
c) Medication							
d) Dosage							

		Yes/No	Insured Person No.
3.	Heart and Circulatory Conditions/Disorders: Chest pain, angina, high cholesterol/lipids, palpitations, congestive heart failure, coronary artery disease, heart attack, bypass surgery/angioplasty, valve disorder/replacement, pacemaker insertion, rheumatic fever, congenital heart condition, varicose veins, thrombosis, blood disorders, etc.		
4.	Urinary Conditions/Disorders: Blood in urine, urinary frequency, painful/difficult urination, Kidney and/or Bladder infections, stones of urinary system, renal failure, dialysis or any other Kidney/Urinary Tract or Prostate Disease		
5.	Musculoskeletal Conditions/Disorders: Joint/back pain, Arthritis, Spondylosis, Joint Replacement or any other Disorder of muscles/bones/joints/ligaments, tendons or discs, gout, herniated disc, amputation/prosthesis		
6.	Respiratory Conditions/Disorders: Shortness/difficulty of breath, Tuberculosis, Asthma, Bronchitis, Chronic Obstructive Pulmonary Disease (COPD), chronic cough , coughing of blood, etc. or any Other Lung/Respiratory Disease		
7.	Digestive Conditions/Disorders: Jaundice, chronic diarrhea, intestinal bleeding/problems/polyps, diseases of the pancreas, liver or gall bladder, hepatitis A/B/C/other, jaundice, Cirrhosis, unexplained weight loss or gain, eating disorder or any other Gastro Intestinal condition		
8.	Cancer/Tumor: Benign or Malignant tumor, any Growth/Cyst, any Cancer		
9.	Brain/Nervous System/Psychiatric Conditions/Disorders: Loss of consciousness, fainting, dizziness, numbness/tingling, weakness, paralysis, head injury, stroke, migraine headaches or chronic severe headaches, sleep apnea, multiple sclerosis, seizures/epilepsy or any other Brain/Nervous System Disease, Mental/Psychiatric disorder		
10.	Female Reproductive Conditions/Disorders: Pelvic pain, abnormal menstrual bleeding, abnormal PAP smear, endometriosis, Fibroid, Cyst/Fibroadenoma, Bleeding Disorder, Pelvic infection or any other Gynecological/Breast cysts/lumps/tumor		
11.	Is any female person proposed to be insured pregnant, tested positive with a home pregnancy test, or in the process of adoption or becoming a surrogate?		
12.	Metabolic and Endocrine Conditions/Disorders: Adrenal/pituitary disorders, lupus, scleroderma, thyroid disorders, any autoimmune/genetic disorder		
13.	Does the person proposed to be insured suffer from any chronic or long-term medical condition, or have any other disability, abnormality or recurrent illness or injury or unable to perform normal activities?		
14.	Does the person proposed to be insured use tobacco products/cigarettes or drinks alcohol?		
15.	Does any of the person proposed to be insured suffers from any infertility related condition?		
16.	Has any person proposed to be insured consulted with or received treatment from any doctor or other health care provider for any other condition or symptom(s)/any psychiatric condition/undergone any hospitalization/illness/surgery/currently taking medication(s) for any condition or medical procedures (including diagnostic testing)?		
17.	Have you or any of the persons proposed to be insured been diagnosed with or undergone surgery for any of the following Critical Illnesses, prior to proposing for this cover - Cancer, Heart Attack, Coronory Artery, Bypass Graft, Heart Valve Replacement/Repair, Coma, Kidney Failure, Stroke, any Transplant, Paralysis, Multiple Sclerosis, Motor Neurone Disease or HIV/AIDS?		

SECTION B: Name and details of Illness/Medicine/Test/Surgery/Diopter grade (for questions answered as YES in SECTION A above)	Date of Last Consultation	Doctor's Name	Hospital Name and Phone No.
Insured Person 1:			
Insured Person 2:			
Insured Person 3:			
Insured Person 4:			
Insured Person 5:			
Insured Person 6:			
Insured Person 7:			

Any other details: _____

Please add additional sheets if required.

Section C: Important Notes:

1. The information that you give to Us on this proposal form or in any supplementary information form or documentation supplied by you or on your behalf will influence Our decision to offer insurance and the terms upon which to offer it. Further, any policy We issue will be based on what you have communicated to Us. It is therefore important that your answers are complete and accurate in all respect.
2. The questions in this proposal are indicative rather than exhaustive. You must provide Us with all information relevant to the risk to be insured, even if it is not the subject of a question in this proposal. If you are in any doubt as to what information should be given, you should liaise with your insurance advisor/company.
3. Acceptance of your proposal would be subject to receipt of complete medical reports (wherever applicable), medical underwriting and realization of full premium amount by the company and the insurance coverage will commence from the date of underwriting by the company.
4. The list of exclusions/inclusions and other policy details are indicative. For complete list and comprehensive details, kindly refer policy wordings.

Section D: Family Physician details:

Name:	Contact No.:

8. PAYMENT DETAILS

1. Payment Details: Please tick (✓) payment option Premium Amount (₹) _____ ❑ Cash ❑ Cheque/NEFT/DD Payment Option ❑ Digital Payment
   Cheque/NEFT/DD Number _____ Cheque/NEFT/DD Date _____ Bank _____
2. For payment of claims/refund through direct bank transfer, please provide the following details: (please enclose a cancelled cheque along with the proposal form)
   Name of the bank _____ Branch _____ City _____
   Account Type _____ IFSC Code _____ Account Number _____

Declaration:
"I/We hereby declare and undertake that the amount paid by me/us as premium for the aforementioned policy is out of my/our lawful and declared source of Income."

9. ELECTRONIC INSURANCE ACCOUNT (EIA) DETAILS OF PROPOSER

Do you have an EIA : ❑ Yes, please quote EIA Number: _____ ❑ No

If applied, please mention your preferred Insurance Repository (IR): _____

Email ID (Registered with Insurance Repository): _____

Your Policy will be credited in your EIA account and your address details as mentioned in the EIA account shall override the address provided in this application for Insurance. We request you to inform the Repository of any changes in the details immediately

*Proofs-

- Identity Proof: Passport/PAN Card/Voter Id/Driving License/Letter from a recognized Public Authority
- Proof of Residence: Telephone Bill/Bank Account Statement/Letter from recognized Public Authority/Electricity Bill/Ration card
- Age Proof: 10th Certificate/DOB certificate/Doctor certificate from recognized hospital/Doctor/Passport/PAN Card/Aadhar card

10. DECLARATIONS

1. **Declaration**
   I) 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.
   ii) 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.
   iii) 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.

iv) I declare that I consent to the company seeking medical information from any doctor or hospital who/which at any time 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.

v) 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.

Date: (DD MM YYYY) Place: _____

Name of Proposer: _____ Signature of the Proposer: _____

2. Authorization for electronic policy fulfillment and service communications (Please read carefully and put a check mark against each before signing)

I hereby consent that the policy documents may be sent to me by email at _____

_____ (Please provide us your email id) _____

I hereby consent to and authorize MAGMA HDI Health Insurance Company Limited ("Company") to make welcome calls, service calls or any other communication (electronic or otherwise) with respect to the proposed or existing policy of Company from time to time and subject to the provisions of applicable law.

Date: (DD MM YYYY) Place: _____

Name of Proposer: _____ Signature of the Proposer: _____

3. Vernacular Declaration

I hereby declare that I have fully explained the contents of the proposal form and all other documents incidental to availing the health insurance from MAGMA HDI Health Insurance Company Limited to the proposer in the language understood by him/her. The same have been fully understood by him/her and the replies have been recorded as per the information provided by the proposer. Replies have been read out to, fully understood and confirmed by the proposer.

Declarant's Name: _____ Relationship with proposer: _____

Signature of declarant: _____ Signature of applicant in vernacular: _____

Date: (DD MM YYYY)

4. Intermediary Declaration

I, _____ (Full Name) in my capacity as an Insurance Advisor/Specified Person of the Corporate Agent/Authorized employee of the Broker/Relationship Officer, do hereby declare that I have explained all the contents of this Proposal Form, including the nature of the questions contained in this Proposal Form to the proposer including statement(s), information and responses(s) submitted by him/her in this Proposal Form to questions contained herein or any details sought herein will form the basis of the Contract of Insurance between the Company and the Proposer, if this Proposal is accepted by the Company for issuance of the Policy. I have further explained that if any untrue statement(s)/information/response(s) is/are contained in this Proposal Form, including addendum(s), affidavits, statements, submissions, furnished/to be furnished, or if there has been a non-disclosure of any material fact, the Policy issued to his/her favour pursuant to this Proposal may be treated by the Company as null and void and all premium paid under the Policy may be forfeited to the Company.

License No./ID (Advisor/Corporate Agent/Broker/Relationship Officer)

Date: (DD MM YYYY) Signature of the Insurance Advisor: _____

I [_____ name of proposer _____] confirm that I have understood all the features/benefits available under this Policy.

Date: (DD MM YYYY) Signature of the Proposer: _____

11. GENERAL INFORMATION

1. Caution

You are obliged to make a full and frank disclosure of all facts material to the assumption of risk in relation to you and every person proposed to be insured that would influence Our decision to issue the policy or the terms on which it is issued and you must not misrepresent any information to Us. The obligation continues until the policy is issued and does not end with the submission of this proposal form. If, therefore, there is any change in the information given herein or new information comes to light before the policy is issued, then you must inform Us of the same in writing without delay. If there is insufficient space to provide additional information, whether as requested or otherwise, then please attach an extra sheet duly signed. If the disclosure obligations are breached then such breach may render any policy issued void.

SECTION 41 OF THE INSURANCE ACT, 1938 - PROHIBITION OF REBATES

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 continuing the policy accept any rebate except such rebate as may be allowed in accordance with the published prospectus or tables of the Insurer.
2. If any person fails to comply with sub-regulation (1) above, he shall be liable to payment of a fine which may extend to Ten Lakh Rupees.

Acknowledgment

Proposal No. _____ Date: (DD MM YYYY)

We acknowledge with thanks the receipt of your proposal and amount by Cash/Cheque/NEFT/Demand Draft/Others _____ of amount of ₹ _____ dated _____ drawn on _____. 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 whatsoever 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 the payment, if any, received from you without interest.

Signature of the receiver and office seal: _____

Terms and Conditions:

- Initial waiting period of 30 days for all Illnesses (except Hospitalization due to Injury)
- Specific waiting period of first two years for specific Illnesses and treatments (mentioned in the Policy wording)
- Pre-Existing Diseases declared and accepted by Us will be covered immediately after 2 years/3 years/4 years of continuous coverage under the Policy (2 years for Premium plan, 3 years for Support Plus and Shield plan and 4 years for Support Plan)
- Sum Insured can be increased at the time of Renewal only. The Company reserves right to approve/reject the increase in Sum Insured. Increased Sum Insured amount will be subject to a fresh waiting period.
- Factors determining the Renewal premium are (i) age slab of the senior most Insured Person at the time of Renewal (ii) any change in the Renewing Policy.
- The liability of the Company does not commence until this Proposal has been accepted by the Company and premium is realized.