Bajaj Allianz General Insurance Co. Ltd.

Bajaj Allianz House, Airport Road, Yerawada, Pune - 411006. Reg No.: 113. CIN: U66010PN2000PLC015329 | UIN: BAJHLIP21127V032021

Caringly yours BAJAJ | Allianz (ii)

 $\label{lem:email:bagichelp@bajajallianz.co.} Email: bagichelp@bajajallianz.com | Website: www.bajajallianz.com | Parameter |$

For Office Use Only:			For Agent Use Unly:			
Scrutiny No.	crutiny No. Receipt No. Policy No.		Intermediary Name	Intermediary Code		

PROPOSAL FORM

Proposal form Unique Reference Number – BAGIC/Health/Individual/001

Health Ensure

Instructions for filling up the form

- Please answer all questions in BLOCK letters
- 2. The Liability of the Company does not commence until this Proposal has been accepted by the Company and premium has been paid
- 3. This Proposal will be the basis of any subsequent policy that we issue to you. It is therefore essential that you provide all the information in this Proposal FULLY AND ACCURATELY and that you provide us with any and all additional information relevant to risk to be insured or our decision as to acceptance of the risk or the terms upon which it should be accepted

Proposer Details							
1) Full Name: Title							
Middle Name							
2) Are you an existing Bajaj Allianz Customer: Yes / No If yes, please mention the Policy No: OG							
3) Gender: Male Female Other 4) Date of Birth D D M M Y Y Y S 5) PAN No.							
6) UID/Unique ID: 7) Bajaj Allianz Employee Code, if proposer is BAGIC/BALIC Employee							
8) Marital Status: Married Single Divorced Widowed 9) No. of Children Sons Daughters							
10) Occupation Business Salaried Professional Student House Wife Retired Others							
11a) Permanent / Residential Address 11 b) Correspondence Address: (All the communications will be sent to the below address)							
House No.							
Landmark/ Landmark/							
Locality							
Area Name							
State							
Tel.							
Mobile Tel.(Office)							
Email Mobile Number							
E-Mail							
12) Educational Qualification: Matriculate Under Graduate Graduate Post Graduate Professionally Qualified							
13) Family Monthly Income: Up to Rs. 20,000 Rs.20,001 to Rs.50,000 Rs.50,001 to Rs.1 lakh Above Rs.1 lakh							
14) In case of any Offer, you would prefer to be contacted by: Phone Email 15) Nationality							
16) Policy Term 1 Year 2 Years 3 Years							
17) Payment mode: Full Payment Installment Payment Monthly Quarterly Half yearly (if opted Installment payment mode)							
18) Premium Payment Zone to be opted Zone A Zone B							
There are Two Zones for Premium payment Zone A: "Following cities has been clubbed in Zone A:-Delhi / NCR, Mumbai including Navi Mumbai, Thane and Kalyan, Hyderabad and Secunderabad, Bangalore,							
Kolkata, Ahmedabad, Vadodara and Surat.							
Zone B: Rest of India apart from Zone A cities are classified as Zone B.							

- Policyholders paying Zone A premium rates can avail treatment allover India without any co-payment.
- But, those, who pay zone B premium rates and avail treatment in Zone A city will have to pay 20% co-payment on admissible claim amount. This Co payment will not be applicable for Accidental Hospitalization cases."
- Policyholder residing in Zone B can choose to pay premium for Zone A and avail treatment all over India without any co-payment.

18) Details Of Persons To Be Insured

Member Name	Relationship with Proposer	DOB (dd/mm /yy)	Age	Gender	Ht (cms)	Wt (kgs)	Nominee	Nominee Relationship with Insured

Member Name		Sum Insured(ind	lividual)	Sum Insured(Floater)					
	-								
Do you smoke cigar ettes or consur	ne tobacco (chew	ving paste) / alcohol, nicotine or ma	rijuana in any form? Please	give duration and d	aily consumption?				
Has any proposal for life, critical illr	Has any proposal for life, critical illness or health related insurance on your life or lives ever been postponed, declined or accepted on special terms? If yes, give details								
Has any of the persons to be insured suffer from/or investigated for any of the following? Disorder of the heart, or circulatory system, chest pain, high blood press stroke, asthma any respiratory conditions, cancer tumor lump of any kind, diabetes, hepatitis, disorder of urinary tract or kidneys, blood disorder, any mental or psychic conditions, any disease of brain or nervous system, fits (epilepsy) slipped disc, backache, any congenital/ birth defects/ urinary diseases, AIDS or positive \textsqr{ No}									
Do you or any of the family memb treatment, regular medication (se] Yes \[\] No If the reply is YES for question 22 ar	elf/prescribed)orp	planned for any treatment / surgery	net with any accident in the y/hospitalization? (Please	e past 4 years and p provide details in th	orior to 4 years and have been t e table given below)				
Name of the person		ne Illness /injury suffered / ffering in the past	Treatment details	Date first	Current Status of the Illnes Diseases/Injury				
<u> </u>	30	normy in the past	uctans	treated	Discuses/Highly				
Have any of your immediate famil was it before age 60 years or after 6		er, mother, brother or sister) have/	had diabetes, hypertension	n, cancer, heart atta	ck, or stroke and at what age?				
	60 years?	er, mother, brother or sister) have/ Relationship with Proposer	had diabetes, hypertension Disease Nat						
was it before age 60 years or after 6	60 years?								
was it before age 60 years or after 6	60 years?				_				
was it before age 60 years or after 6	60 years?				_				
was it before age 60 years or after 6	60 years?				ck, or stroke and at what age? At what Age illness suffe				

Amount	Transaction No.	Transaction Date	Bank Name	Branch	

Declaration

I/ We 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/ We am/ are authorized to propose on behalf of these other persons.

I understand that the information provided by me will form the basis of the Individual Policy/floater Policy, and the proposal is subject to the Board approved underwriting policy of the Company and that the Policy will come into force only after Company's full receipt and realization of the premium chargeable.

I/We further declare that I/we will notify in writing any change occurring in the occupation or general health of the Insured Person(s) to be insured/proposer after the proposal has been submitted but before communication of the risk acceptance by the Company. Upon renewal of Policy, I/We agree to abide by the standard Terms and Conditions, unless otherwise mentioned by the Company in renewal Policy Schedule or attachments thereto.

I/ We declare and consent to the company seeking medical information from any doctor or from a hospital/institution who at anytime has attended on the Proposer/Insured Person to be insured or from any past or present employer concerning anything which affects the physical or mental health of the life to be assured/ proposer and seeking information from any insurance company to which an application for insurance on the life to be assured/proposer has been made for the purpose of underwriting the proposal and/or claim settlement.

I/We authorize the company to share information pertaining to my proposal including the medical records for the sole purpose of proposal underwriting and/ or claims settlement and with any reinsurer, Governmental and/or Regulatory authority.

Date: D M M Y Y Y Y	
Place:	Signature/ Thumb Impression of the Proposer
Certified that the contents of the Proposal Form and documents have been fully explained to the Proposer in the language known understood the significance of the proposed contract	ı to him and that he/they have fully
Date: D M M Y Y Y Y	
Place:	Signature (On behalf of Proposer)

INSURANCE ACT 1938 SECTION 41- 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 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 prospectus or tables of the insurer. 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.

^{*}Please read declaration wordings carefully before signing the proposal form.

^{**}This is required only where, for any reason, the Proposal Form and other connected papers are not filled by the Prospect/Proposer or if the Prospect/Propose is not knowing English.

			PUR	TABILITY FURI	VI					
PA	RTI									
1)	Name of the Policyhol	der/insured(s)								
2)										
3)	Address of policyholder / insured									
4)	Details of existing insurer									
	i. Name of the product									
	ii. Sum Insured									
	iii. Cumulative Bonus									
	iv. Add ons/Riders taken									
	v. Policy Number									
5)	Details of the proposed insurance									
	i. Name of the product proposed/intended to take									
	ii. Sum insured proposed									
	iii. Whether Cumulative Bonus to be converted to an enhanced sum insured									
6)	Reason (s) of portabili	ty								
7)		to be included in the policy to be								
		Details of previous				Previous	nsurance	First policy		
	First Name of Insured	health insurance policy	Health Id card number	Sum Insured	СВ	From dd/mm/yy	To dd/mm/yy	inception date		
		/ Policy number				Trom dd/mm/yy	10 dd/11111/yy			
L										
End	closure: Photocopy of th	ne existing policy documents				1		1		
Da	te//									
	D.T. II									
	RTII									
1.		usions / time bound exclusion h	ave longer exclusion pe	riod than existir	ig policy					
	(Please indicate Yes /N	No) Yes No								
2	If		da							
2.		ten consent to the declaration be		+ (c) ic d	ous lucare n	mara than the provious	naligy tarms barab	y agree to observe the		
		waiting period for the following iod for the following diseases (s		ι (δ) 15α	ays/years r	nore than the previous	policy terms, mereb	y agree to observe the		
							Signature of Police	holder		
								,		
A	CKNOWLEDGMENT:									
R	eceived from Ms. / Mrs.	/Mr:								
SI	um of Rs.	through Ca	sh# /Cheque /DD /Cr	edit Card / Deb	it Card No.		against your propos	al for Health Policy.		
							3 7 1 1 1			
	Cignoture of D-1-1 All'	onz Official / Internation								
	Signature of Bajaj Allia	anz Official/ Intermediary								
R	aiai Allianz Official / Inte	ermediary Name:								
0										

Note: Neither the submission of a completed proposal for insurance or any payment for any policy sought oblige the Company to agree to issue a policy, which decision is and always shall be in the Company's sole and absolute discretion.