BAJAJ | Allianz

Bajaj Allianz General Insurance Co. Ltd. G.E. Plaza, Airport Road, Yerawada, Pune - 411 006.

For Office Use Only:

Scrutiny No.	Receipt No.	Policy No.

For Agent Use Only:

Emp/LG Code	Loan Account Number	IMD Code	Sub IMD Code	IMD Name	Mobile No.

HEALTH GUARD INDIVIDUAL POLICY PROPOSAL FORM

Instructions For Filling Up The Form:-

1. 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 First Name

Middle Name Surname

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 Y 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_____

11 a) Permanent / Residential Address

House No. House Name

Landmark/ Locality

Road/ Area Name

City/District

State Pin Code

Tel.

Mobile

Email

11 b) Correspondence Address: (All the communications will be sent to the below address)

House No. House Name

Landmark/ Locality

Road/ Area Name

City/District

State Pin Code

Tel.(Res.)

Tel.(Office)

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) Details of the persons to be insured

Sr No	Name	DOB (dd/mm /yy)	Age	Gender (M/F)	Ht	Wt	Occupation	Relation	Sum Insured	Premium	Nominee	Relationship of Nominee

17) Period of Insurance: From D D M M Y Y Y Y To D D M M Y Y Y Y

18) Co-Payment (Waiver for non-network Hospitals) Yes No

19) Do you smoke cigarettes or consume tobacco (chewing paste) / alcohol, nicotine or marijuana in any form? Yes No
Please give duration and daily consumption _____

20) 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 pressure, stroke, asthma any respiratory conditions, cancer tumor lump of any kind, diabetes, hepatitis, disorder of urinary tract or kidneys, blood disorder, any mental or psychiatric conditions, any disease of brain or nervous system, fits (epilepsy) slipped disc, backache, any congenital/ birth defects/ urinary diseases, AIDS or positive HIV, If yes, indicate in the table given below. Yes No

21) Have you or any of your immediate family members (father, mother, brother or sister) have/ had cancer, heart attack, or stroke and at What age? Prior to age 60yrs? Yes No

If yes please provide details

22) Please confirm, if any of the person to be insured is pregnant (For Females Only)If yes, please state how many months?_____

☐ Yes ☐ No

23) Do you or any of the family members to be covered have/had any health complaints/met with any accident in thepast 4 years and have been taking treatment/ hospitalization? (Please provide details in the table given below)

☐ Yes ☐ No

24) Illness/injury details of the past 4years and prior to 4 years.

Sr. No	Name of the person	Name of the Illness /injury suffered / suffering in the past 4 years	Treatment details	Date first treated	Name of the Illness / injury suffered any time in the past (prior to 4 years)	Treatment details	Date first treated	Current Status of the Illness/ Diseases/Injury

25) 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_____

26) Family Doctor Details:

Name:

Qualification: Mobile

Address:

Reg No:

Voluntary Deductible

Deductible Amount in Rs Please tick the opted deductible Discount (%)

Deductible Amount in Rs	10,000	15,000	25,000	50,000	75,000	100,000	150,000	200,000	250,000
Please tick the opted deductible									
Discount (%)	10.00%	15.00%	17.50%	20.00%	22.50%	25.00%	27.50%	30.00%	32.50%

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 insurance policy, is subject to the Board approved underwriting policy of the insurance company and that the policy will come into force only after full receipt 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 life to be insured/proposer after the proposal has been submitted but before communication of the risk acceptance by the company.

☐ I/We declare and consent to the company seeking medical information from any doctor or from a hospital who at anytime has attended on the life to be insured/proposer 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 Governmental and/or Regulatory authority."

Date :_____

Place :_____

Signature of Proposer

Name and Designation:_____

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 FAULT IN COMPLYING WITH THE PROVISIONS OF THIS SECTION SHALL BE PUNISHABLE WITH FINE WHICH MAY EXTEND TO FIVE HUNDRED RUPEES. Certified that the contents of the Proposal Form and documents have been fully explained to the Proposer and that he/they have fully understood the significance of the proposed contract***

Date :_____

Place :_____

Signature of Proposer

Name and Designation:_____

*** This is required only where, for any reason, the Proposal Form and other connected papers are not filled by the Prospect/Proposer.

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

PORTABILITY FORM

PART I

1) Name of the Policyholder / insured (s)_____

2) Date of Birth / Age _____

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 portability_____

7) No of family member to be included in the policy to be ported _____

First Name of Insured	Details of Previous Health Insurance Policy / Policy No.	Health ID Card number	Sum Insured	CB	Period of Insurance		First Policy inception date
					From dd/mm/yyyy	To dd/mm/yyyy	

Enclosure: Photocopy of the existing policy documents

Date D D M M Y Y Y Y

Signature of Proposer

PART II

1. Whether the PED exclusions / time bound exclusion have longer exclusion period than existing policy (Please indicate Yes /No) ☐ Yes / ☐ No

2. 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 .....days/years more than the previous policy terms, I hereby agree to observe the additional waiting period for the following diseases (s)/ treatments (s)

Signature of Policyholder