



**18) Details Of Persons To Be Insured**

Sr No	Name	Relationship with Proposer	DOB (dd/mm/yy)	Age	Gender (M/F)	Ht (cms)	Wt (kgs)	Nominee Name	Nominee Relationship with Insured

**Plan and Sum Insured Details:**

Member Name	ABHA Number (14 Digits)	Plan opted (Silver/Gold/Platinum)	Sum Insured (individual)	Sum Insured (floater)

**19) Selection of Rider/Add on**

Member Name	Please Select only one of the below option( Between Room Rent Capping and Option for waiver of Room Capping)		Non-Medical Expenses Cover (Rider)** Yes /No
	Room Rent Capping*	Option for Waiver of Room Capping (for Single Private AC Room)	
	Applicable for (Sum Insured - 3 Lacs & Above)	Applicable for (Sum Insured - 5 Lac & 7.5 Lac)	

\*\*Note- This rider can be availed with Sum Insured options of INR 5,00,000 and above on payment of extra premium

\*Note: By Opting for room rent capping option you will be eligible for discount on premium as mentioned in the table below. The room rent would be restricted to 1.5% of the base Sum Insured maximum up to INR 7,500 per day. This discount is applicable for Sum Insured 3 Lacs and above only.

Base SI	Discount on Individual Policy	Discount on Floater Policy
Rs. 300,000 and above	10%	5%

**Health Prime Rider** | Co-Pay:  YES  NO

**Individual**  **Floater** Plan Option \_\_\_\_\_

**Respect Rider:**  YES  NO (If Respect Rider is opted, please furnish details in the attached annexure)

20) Do you smoke cigarettes or consume tobacco (chewing paste) / alcohol, nicotine or marijuana in any form? Please give duration and daily consumption?

21) 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

22) 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.

\_\_\_\_\_ Yes/ \_\_\_\_\_ No

23) Have you or any of the persons proposed to be insured were/are detected as Covid positive? \_\_\_\_\_ Yes/ \_\_\_\_\_ No

24) Do you or any of the family members to be covered have/had any health complaints/met with any accident in the past 4 years and prior to 4 years and have been taking treatment, regular medication (self/ prescribed) or planned for any treatment / surgery / hospitalization?

\_\_\_\_\_ Yes/ \_\_\_\_\_ No If the reply is YES for question 22 to 24 , please share details in below table

Name of the person	Name of the Illness /injury suffered / suffering in the past	Treatment details	Date first treated	Current Status of the Illness/ Diseases/Injury	Vaccinated against COVID-19? (Yes/No)

25) Have any of your immediate family members (father, mother, brother or sister) have/ had diabetes, hypertension, cancer, heart attack, or stroke and at What age? If yes, was it before age 60 years or after 60 years?

Member Name	Relationship with Proposer	Disease Name	At what Age illness suffered

26) Payment Mode  Full Payment  Installment Payment

If Installment Payment Mode is opted, please provide below details:  Monthly  Quarterly  Half Yearly  Annual

27) Payment Details:  Cash  Cheque  DD  Credit Card  Debit Card

Amount	Transaction No.	Transaction Date	Bank Name	Branch

28) In case of any Offer, you would prefer to be contacted by:  Phone  Email

#### 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 hereby authorize and give my/our consent to Company to collect my/our personal and medical information/data available in my/our Ayushman Bharat Health Account (ABHA). Further I/we hereby authorise Company to use/share the information/data, pertaining to my proposal and/or collected from my/our ABHA, with reinsurer, Service Provider and or with any Governmental and/or Regulatory authority, for the sole purpose of proposal underwriting and/or claims settlement and or to comply with applicable laws/regulations.

Date : \_\_\_\_\_

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 to him and that he/they have fully understood the significance of the proposed contract\*\*

Date : \_\_\_\_\_

Place : \_\_\_\_\_

\_\_\_\_\_

Signature (On behalf of Proposer)

\*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.

#### 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.



To support our Go Green initiative, we will send policy copy link on your registered mobile number / email id. This is a digitally signed valid document. Please tick the box, if you still want to receive physical copy of your insurance policy.



#### ACKNOWLEDGMENT:

Received from Ms. / Mrs. / Mr: \_\_\_\_\_

sum of Rs. \_\_\_\_\_ through Cash# / Cheque / DD / Credit Card / Debit Card No. \_\_\_\_\_ against your proposal for Health Policy.

Date:

D	D	M	M	Y	Y	Y	Y
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\_\_\_\_\_

Signature of Bajaj Allianz Official/ Intermediary

Bajaj Allianz Official / Intermediary Name: \_\_\_\_\_

Time : \_\_\_\_\_

Place : \_\_\_\_\_

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.

**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 number	Health Id card number	Sum Insured	CB	Previous Insurance		First policy inception date
					From dd/mm/yy	To dd/mm/yy	

Enclosure: Photocopy of the existing policy documents

Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_

Signature of Policyholder

**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

**DECLARATIONS – PHYSICAL PROPOSAL FORM**

- Are you or any of the proposal applicants a PEP\* or a close relative of PEP\*?

If yes, please share the details \_\_\_\_\_

“Politically Exposed Persons” (PEPs) are individuals who are or have been entrusted with prominent public functions in a foreign country, e.g., Heads of States/Governments, senior politicians, senior government/judicial /military officers, senior executives of state-owned corporations, important political party officials, etc.”  Yes /  No

- I/we hereby give my/our consent to the Company to verify and obtain my/our identity/address proof through CERSAI records or National Securities Depository Limited Portal for the purpose of undertaking KYC verification.  Yes /  No
- I/we hereby declare and confirm that the premium has been paid out of legally acquired sources of income and the subsequent premiums if any, will continue to be paid out of legally declared and assessed source of income.  Yes /  No
- I/We hereby give voluntary consent to BAGIC/Company to share my/our personal information and data provided in this proposal form with its group companies or any other person in connection with the Insurance Policy or otherwise, including for providing products and services of group companies that may be of interest to me/us, to be used in accordance with their respective privacy policies and subject to appropriate measures being in place to safeguard my/our personal information.  Yes /  No

It is mandatory to keep your policy with updated contact (Mobile No., Email ID and PAN Card) and bank account details, to process any of your service requests faster and hassle-free in future.

You can update the same through Caringly yours App – <http://onelink.to/v9zp7c>, WhatsApp Service {Say 'Hi' on WhatsApp - +91 75072 45858}, Contact our 24-Hour Call Center at 1800-209-5858, 1800-102-5858, Give a Missed Call on – 8080945060, SMS “WORRY” to 575758, Email – [bagichelp@bajajallianz.co.in](mailto:bagichelp@bajajallianz.co.in), website – <https://www.bajajallianz.com/general-insurance.html>, contact your agent or nearest branch.