

Bajaj Allianz General Insurance Co. Ltd.

Bajaj Allianz House, Airport Road, Yerawada, Pune - 411 006. Reg. No.: 113

CIN: U66010PN2000PLC015329 | UIN: BAJHLIP23143V012223

For more details, log on to : www.bajajallianz.com or call at : **Sales - 1800 209 0144 / Service - 1800 209 5858** (Toll Free No.)

21. Plan and Sum Insured Details

Member Name	In-Patient Hospitalisation Sum Insured

22. Change in Room rent options: General Ward Twin Sharing 1% of SI max up to 5000 1.5% of SI max 7500 2% of SI max up to 7500 Default

(Note : The Base Plan will have Single Pvt AC Room by Default for SI 3 lacs to 10 lacs and for SI above 10 lacs only Actuals will be applicable, Option selected by proposer will be applicable to all dependent members)

23. Pre-hospitalization Medical Expenses : 30 90 180 240 (Days) Default

(Note: The Base Plan will have 60 days by Default , 240 days will be applicable only for SI above 50 lacs, Option selected by proposer will be applicable to all dependent members)

24. Post-hospitalization Medical Expenses : 30 60 180 240 (Days) Default

(Note: The Base Plan will have 90 days by Default , 240 days will be applicable only for SI above 50 lacs, Option selected by proposer will be applicable to all dependent members)

25. Waiting period (pre-existing disease): 12 months 24 months Default

(Note: The Base Plan will have 36 months by Default , Option selected by proposer will be applicable to all dependent members)

26. Waiting period (specific disease) : 12 months Default

(Note: The Base Plan will have 24 months by Default , Option selected by proposer will be applicable to all dependent)

27. Major Illness and Accident Multiplier: Yes No

(Note : Optional cover opted by proposer will be applicable to all members)

28. International Cover (Emergency Care only): Yes No

(Note : Optional cover opted by proposer will be applicable to all members)

29. Loss of income (without infection) (applicable only for Self, Spouse and dependent Parents for individual policy & Self and Spouse for floater policy)

Name of Insured	Relation with proposer	Yes / No
1.		<input type="checkbox"/> Yes <input type="checkbox"/> No
2.		<input type="checkbox"/> Yes <input type="checkbox"/> No
3.		<input type="checkbox"/> Yes <input type="checkbox"/> No
4.		<input type="checkbox"/> Yes <input type="checkbox"/> No

(Note : If dependent members are opting this cover, then it is mandatory for the proposer to opt this cover)

30. Fitness Discount

Please share the details of the marathon run in the table below

	Name of Marathon	Date (within 12 months)	No. of Kilometer run
Member 1			
Member 2			
Member 3			
Member 4			
Member 5			

31. Do you have Motor, Health, Home, Cyber and Pet Insurance with a premium more than INR 2500.

If yes please provide the details in below table

	Policy number	Policy period	LOB
Member 1			
Member 2			
Member 3			
Member 4			
Member 5			

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

33. 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 _____

34. 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), vertebral column disorder/s, backache, any congenital/ birth defects/ urinary diseases, AIDS or positive HIV. Yes No

35. 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? (Please provide details in the table given below)

If the reply is YES for question 33 and 34, please share details in below table

Member Name	Name of the Illness/injury suffered/suffering in the past	Treatment details	Date first treated	Current Status of the Illness/Diseases/Injury

36. 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

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

37. Payment Details: Cash Cheque DD Credit Card Debit Card

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 ____ / ____ / ____
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.

ACKNOWLEDGEMENT:

Received from Ms. / Mrs. / Mr: _____ sum of Rs. _____ through Cash# / Cheque / DD / Credit Card / Debit Card No. _____ against your proposal for Health Policy. Signature of Bajaj Allianz Official/ Intermediary: _____
Date: _____ Time: _____ Place: _____ Bajaj Allianz Official / Intermediary Name: _____

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

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](tel:1800-209-5858), [1800-102-5858](tel:1800-102-5858), Give a Missed Call on – [8080945060](tel:8080945060), SMS “WORRY” to [575758](tel:575758), Email – bagichelp@bajajallianz.co.in, website – <https://www.bajajallianz.com/general-insurance.html>, contact your agent or nearest branch.