

## PROPOSAL FORM

URN No.: AH/2023-24/HL-12

Proposal no.: \_\_\_\_\_

Intermediary Code: \_\_\_\_\_

This is an application for insurance and issuance of this does not amount to acceptance of proposal by us. Commencement of risk under this proposal is subject to acceptance of the risk by us and receipt of premium.

The information declared by you in this form is the basis for issuance of the policy. Please answer all questions carefully. Any incomplete, incorrect or partially correct answers may lead to rejection of the proposal and also might lead to cancelation of policy.

Please fill-up this form in CAPITAL LETTERS

### 1. PROPOSER'S DETAILS

Name (Mr/Mrs/Ms/D):

Date of Birth:         Gender:  Male  Female  Others

Unique Govt ID No.:  PAN Card:

Annual Income (in ₹ Lakhs):  Upto 3  3-6  6-10  10-15  15-20  20-25  >25

E-Mail ID:

- i. Is Nationality or Residence Status of either the Proposer or any of the Insured Person(s) is 'other than Indian' (i.e. the Nationality or Residence Status is Non Resident Indians (NRI)/ Overseas Citizen of India (OCI)/ Foreign Nationals)?  Yes\*  No
- ii. If you are Resident Indian National and want to opt out of Global Cover for Planned Hospitalization  Yes\*  No

\*If the answer to (i) or (ii) above is 'Yes', you are eligible for a premium discount and 'Global Cover for Planned Hospitalization' as a Benefit is not available under this policy and no claim shall be admissible under this section

Nationality:  Indian  Foreign Nationals

Residence Status\*:  Indian Resident  Non Resident Indian (NRI)  Overseas Citizen of India (OCI)  Foreign National

Mobile No.:

Residential Address^:

Landmark:  Area:

City/Town:  Pin Code:

District:  State:

Country:

#Correspondence Address and Contact Number in India (For NRI/Foreign National/ OCI proposer)

Address:

Landmark:  Area:

City/Town:  Pin Code:

District:           State:

Mobile:

Passport Number:

**Important Notes:**

**^Note 1:**

- Here 'Address' implies the place where the person ordinarily resides. In case proposed Insured Person(s) reside at multiple addresses, then address of the person residing in the highest zone to be provided.  
 Zone definitions as mentioned in the prospectus (wherein Zone A is highest followed by Zone B and Zone C respectively.)
- Declared 'Address' will form the basis for the calculation of the premium.
- 'Address' is a material fact for calculation of the premium. "Material facts" for the purpose of this Policy shall mean all relevant information sought by the company in the proposal form and other connected documents to enable it to take informed decision in the context of underwriting the risk.
- Any misrepresentation or misdescription of the same by the policyholder may lead to termination of the policy as per policy terms and conditions and accordingly all premium paid thereon shall be forfeited to the Company.

**Note 2:**

- In case of Non Resident Indians (NRI)/ Overseas Citizen of India (OCI)/ Foreign Nationals) customers, Zone A premium shall be applicable, irrespective of residential address in India.

TATA Group Employee  TATA Group Employee ID: \_\_\_\_\_

**2. POLICY DETAILS**

Proposed Policy Commencement Date:

Policy Tenure:  1 Year  2 Year (5% premium discount)  3 Year (10% premium discount)

Sum insured type:  Floater  Individual

**3. DETAILS OF THE PERSON(S) TO BE INSURED**

Sr No.	Name of the Insured Person	Gender	Relationship with Proposer*	Date of Birth	Height	Weight	Sum Insured (Rs)#
1.		M/ F/ Others		DD MM YYYY	(cms)	(Kgs)	
2.		M/ F/ Others		DD MM YYYY	(cms)	(Kgs)	
3.		M/ F/ Others		DD MM YYYY	(cms)	(Kgs)	
4.		M/ F/ Others		DD MM YYYY	(cms)	(Kgs)	
5.		M/ F/ Others		DD MM YYYY	(cms)	(Kgs)	
6.		M/ F/ Others		DD MM YYYY	(cms)	(Kgs)	
7.		M/ F/ Others		DD MM YYYY	(cms)	(Kgs)	

\*Allowed relations (Self, Spouse, children and dependent parents/parents in law)

#Sum Insured options available Rs. (5, 10, 15, 20, 25, 50, 75, 100, 200, 300 Lakhs); Same Sum Insured for all members in floater option

**4. NOMINEE DETAILS**

In the event of the death of the Proposer any payment due under the Policy shall become payable to the nominee in accordance with the Policy terms and conditions.

Nominee Name	Date of Birth*	Relationship	Address of the Nominee

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

Appointee Name	Relationship	Address of the Appointee

**5. EXISTING/PREVIOUS INSURER DETAILS**

Is the proposer or any of the persons proposed, already Insured under a health plan with Tata AIG General Insurance Company Ltd. or any other insurer or is a proposal pending for Policy issuance? If yes, please indicate the Policy/ Application number(s): \_\_\_\_\_

Since when continuously insured: 

D	D	M	M	Y	Y	Y	Y
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Do you want Us to consider these details for portability\*?  Yes  No

*\* Please note that continuity of benefits shall NOT be considered if the details are not provided. You need to approach Us at least 45 days prior to your expiry date to avoid any break in coverage. Please submit all previous year insurance policy copies.*

Policy No.	Name of Insured Person	Insurer	Period of Insurance		Sum Insured & Cumulative bonus (Rs.)	Claims lodged during the preceding years along with the diagnosis
			From DD/MM/YYYY	To DD/MM/YYYY		
			DD/MM/YYYY	DD/MM/YYYY		
			DD/MM/YYYY	DD/MM/YYYY		
			DD/MM/YYYY	DD/MM/YYYY		
			DD/MM/YYYY	DD/MM/YYYY		
			DD/MM/YYYY	DD/MM/YYYY		
			DD/MM/YYYY	DD/MM/YYYY		
			DD/MM/YYYY	DD/MM/YYYY		

**6. MEDICAL AND LIFESTYLE DETAILS**

**A. Medical History:**

Please answer the below mentioned questions individually in Yes(Y)/No (N):

You must answer the questions truthfully. Not doing so would lead to termination of your policy.

Please answer each of the following questions individually for each Insured Person by ticking the relevant box.	Insured Person						
	1	2	3	4	5	6	7
Have you or any of the persons proposed for insurance, ever suffered from or taken treatment, or hospitalized for or have been recommended to take investigations / medication / surgery or undergone a surgery for the following medical conditions?							
<input type="checkbox"/> Chest Pain / Heart Disease/Insulin Dependent Diabetes	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
<input type="checkbox"/> Arthritis	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
<input type="checkbox"/> COPD	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
<input type="checkbox"/> Kidney Failure, Dialysis	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
<input type="checkbox"/> Liver Cirrhosis/Hepatitis B or C	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
<input type="checkbox"/> Cancer	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
<input type="checkbox"/> HIV/AIDs	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
<input type="checkbox"/> Stroke, Epilepsy, Paralysis	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
<input type="checkbox"/> Psychiatric, Mental Illness or disorder	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
<input type="checkbox"/> Ulcerative Colitis/Crohn's disease	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
<input type="checkbox"/> Auto-immune diseases	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
<input type="checkbox"/> STDs	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
Any other illness/disease/injury/disability in the past other than for childbirth, flu or for minor injuries that have completely healed?	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
Are you or any persons proposed on regular medication (including any Ayurvedic treatment) or Hospitalized for any illness/ surgery or awaiting any procedure/treatment?	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N

Do you have any signs, symptoms, illness or injury including knee joint ligament tear or back pain/ Swelling or Pain in any part of body / Breathlessness on mild effort / dizziness more than once in last 6 months for which medical consultation / treatment / investigation has been required.	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
Have you ever been diagnosed with any of these medical conditions with or without any follow-up tests/medications? – Elevated Blood Sugar/ Type 2 Diabetes Mellitus/ Elevated Blood Pressure/ Hypertension/High Cholesterol/ Asthma	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
Have you ever been diagnosed with any Thyroid Disorder with or without any follow-up tests/medications?	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
Is any of the insured pregnant currently? If yes, please mention expected date of delivery (EDD). Any history of pregnancy related complications?	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
EDD: DD/MM/YYYY							
Has any application for life, Health or critical illness insurance ever been declined, postponed, loaded or been made subject to any special conditions by any insurance company?	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
Has any health or life insurance policy ever been terminated in the past?	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
Have you undergone any annual health check-up or routine medical examination in the past year? (If yes, please provide details of any findings or results)	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N

**B. Detailed information in case any of the questions in section 6 (A) is ticked 'Yes'.**

(Please send us medical documents along with this application form.)

Insured Name	Name of Disease (surgical)	Operative status	Type of surgery	Treatment status	Complication(s)

Insured Name	Name of Disease (medical)	Date of diagnosis	Medication history	Mode of medication	Progress	Complication(s)

Insured Name	Remarks

**C. Lifestyle Information**

Does any person proposed to be insured smoke or consume Gutka/Pan Masala or Alcohol?  Yes  No

If yes please indicate the name and quantity per day.	Insured Person						
	1	2	3	4	5	6	7
Alcohol (in ml) • Per day • Per week • Per month • Occasionally	Quantity + Frequency + Duration						
Smoking (No of Cigarettes or Bidis) • Per day • Per week • Per month • Occasionally	Quantity + Frequency + Duration						
Pan Masala/Tobacco (in gms) • Per day • Per week • Per month • Occasionally	Quantity + Frequency + Duration						
Other habit forming substances/addictive (Quantity consumed) • Per day • Per week • Per month • Occasionally							

**7. PAYMENT DETAILS**

Name of the Premium Payer: (if different from proposer)

Relationship with the proposer: (if different from proposer)

Premium Amount (in Rs.)

Instrument type:  Cheque  Debit Card  Credit Card  Others

Please make a Crossed Cheque/DD/Pay Order in favour of 'TATA AIG General Insurance Company Limited' only.

Sources of funds:  Salary  Business  Other

**AML guidelines:**

1. I/we hereby confirm that all premiums paid / payable in future will be from bonafide sources and not paid out of proceeds of crime and that such premiums are not disproportionate to my/our income. I / we understand that the Company has the right to call for documents to establish sources of funds and to cancel the insurance policy in case I / we are found guilty by any competent court of law under any of the statutes, directly or indirectly governing the prevention of money laundering law in India.

2. I / we are not Politically Exposed Persons \*\* nor are their close relatives/family members/associates. I / we shall keep the company informed if we subsequently become a Politically Exposed Person/close relative/family member/associate of politically exposed person(s).

\*\*"Politically Exposed Persons" shall have the meaning assigned to it under Prevention of Money-Laundering (Maintenance of Records) Amendment Rules, 2023 as amended from time to time.

**Type of Organization making the payment (Pls tick)**

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Limited company            | <input type="checkbox"/> Government organization | <input type="checkbox"/> Non-Governmental Organization (NGO) |
| <input type="checkbox"/> Society                    | <input type="checkbox"/> Trust                   | <input type="checkbox"/> Partnership                         |
| <input type="checkbox"/> International Organization | <input type="checkbox"/> Cooperatives            | <input type="checkbox"/> Section 25 Company                  |

Signature of Proposer: \_\_\_\_\_

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

**8. BANK DETAILS (REQUIRED FOR REFUND/CLAIMS)**

As per Regulatory requirements, we can effect payment of refund / claims only through Electronic Clearing System (ECS) / National Electronics Funds Transfer (NEFT) / Real Time Gross Settlement (RTGS) / Interbank Mobile Payment Service (IMPS)

For this purpose, please submit the following details of the proposer's bank account.

Name of the account holder:	
Name of the bank:	
Branch Bank:	
Account no.:	
Bank IFSC code:	
Account Type:	<input type="checkbox"/> SB Account <input type="checkbox"/> Current Account <input type="checkbox"/> Others (please specify)

**9. DECLARATION & WARRANTY ON BEHALF OF ALL PERSONS PROPOSED TO BE INSURED**

- 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.
- 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.
- 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.
- 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.
- 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.

Signature of the Proposer: \_\_\_\_\_

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

- GoGreen:* I would like to protect my environment and would like to help save paper by authorizing Tata AIG General Insurance Company Limited to send all my policy and service related communication to the email id as mentioned in this application form. For detailed terms, conditions, exclusions and policy wordings please refer our website ([www.tataaig.com](http://www.tataaig.com))

**10. DECLARATION/VERNACULAR DECLARATION**

The content of this form along with product benefits, terms/conditions and exclusions have been clearly explained to me. I/we have understood these and confirm to abide by the policy terms & conditions.

**Signature of the Proposer:** \_\_\_\_\_

**Name & Signature of agent/intermediary with code:** \_\_\_\_\_



**ACKNOWLEDGEMENT (TO BE GIVEN TO CUSTOMER)**

Proposal Number: \_\_\_\_\_

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

Name of the Proposer \_\_\_\_\_

We acknowledge with thanks the receipt of your proposal for Tata AIG MediCare Premier and amount by  cheque  Demand Draft others \_\_\_\_\_ of amount of ₹\_\_\_\_\_. Neither the submission to us of a completed proposal for insurance nor any payment towards this application 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 to make any payment if proposal is not accepted by us or you do not accept the terms of counter offer or premium is not received by us in full and in time, or non-fulfillments of Pre-Policy Checkup and/or additional information requested by us. We shall have no liability to make any payment under the Policy if proposal is under-process & claim arises in the interim period before the decision on the proposal is given by us. In case of counter offer you need to revert to Us with consent and additional premium (if any), within 15 days of the issuance of such counter offer letter. In case, You neither accept the counter offer nor revert to Us within 15 days, we shall cancel application and refund the amount paid against this proposal without interest subject to deduction of the Pre Policy Check up charges, as applicable. If we do not accept the proposal, we will inform you and refund any payment received from you without interest within next 10 days subject to deduction of the Pre-Policy Check up charges, as applicable.

**TATA AIG GENERAL INSURANCE COMPANY LIMITED**

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IRDA of India Registration No: 108 | CIN: U85110MH2000PLC128425 | Tata AIG MediCare Premier UIN: TATHLIP24159V042324