Bajaj Allianz General Insurance Company Limited
Regd. Office & Head Office: Bajaj Allianz House, Airport Road, Yerwada, Pune - 411 006 | IRDAI Registration No.113
CIN: U66010PN2000PLC015329.
UIN : Health Guard - BAJHLIP23065V052223 | Add On Cover (Waiver of Room Capping - BAJHLAP21577V012021)
UIN: BAJHLAP21586V012021 | UIN - BAJHLIA22169V012122

Caringly yours

BAJAJ | Allianz

For Office Use Only:

Scrutiny No.	Receipt No.	Policy No.

For Agent Use Only:

IMD Code	Sub IMD Code	IMD Name	Mobile No

PROPOSAL FORM

Proposal Form Unique Reference Number: BAGIC/ Health/ Individual/ 005

HEALTH GUARD

Instructions for filling up the 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 the Company issues to you. It is therefore essential that you provide all the information in this Proposal FULLY AND ACCURATELY and that you provide the Company with any and all additional information relevant to risk to be insured or its 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_____

11a) 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) Nationality

15) Policy Term ☐ 1 Year ☐ 2 Years ☐ 3 Years

16) Premium Payment Zone- ☐ Zone A ☐ Zone B ☐ Zone C

There are Three Zones for Premium payment-
Zone A
Delhi / NCR, Mumbai including (Navi Mumbai, Thane and Kalyan), Hyderabad and Secunderabad, Kolkata, Ahmedabad, Vadodara and Surat.
No Co-Payment
Zone B
Rest of India apart from zone A & zone C
*** 15% Co-Payment Applicable if treatment availed in Zone A locations**
Zone C
Goa, Chhattisgarh, Punjab, Chandigarh, Jammu & Kashmir, Jharkhand, Arunachal Pradesh, Bihar, Himachal Pradesh, Nagaland, Odisha, Sikkim, Tripura, Uttarakhand, Manipur, Meghalaya, Mizoram, Andaman & Nicobar Islands
*** 20% & 5% Co-Payment Applicable if treatment availed in Zone A & Zone B locations respectively**

Note:-
Policyholder residing in Zone B and Zone C can choose to pay premium of Zone A and avail treatment all over India without any co-payment.

17) Voluntary Co-Pay Discount: ☐ 10% ☐ 20%

Note: If opted voluntarily by the Insured then Insured will be eligible of additional 10% or20% discount respectively on the policy premium. In case of a claim has been admitted under In-patient Hospitalisation Treatment then, the insured person shall bear 10% or 20% respectively of the eligible claim amount payable under this cover

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	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**

☐ **Individual** ☐ **Floater** Plan Option _____

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 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.

GoGreen 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

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.

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 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