

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

The nominee must be an immediate relative of the Proposer.

*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
---	---	---	---	---	---	---	---

Do you want Us to consider these details for portability* Yes No

* In case of portability, please fill up IRDAI portability form. Please note that continuity of benefits shall NOT be considered if the details are not provided. You need to approach 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		SI & Cumulative bonus / Rs.	Claims lodged*
			From D D M M YYYY	To D D M M YYYY		

*during the preceding years along with the diagnosis

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	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/STDs	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

URN No. AH/2017-18/HL-01

