THE NEW INDIA ASSURANCE CO. LTD.

Regd. & Head Office: 87, M.G. Road, Fort, Mumbai- 400 001.

PROPOSAL FORM NEW INDIA FLOATER MEDICLAIM POLICY

(URN: NIA/Health/23-24/NP)

Agency Details:

Name of the Intermediary	
Intermediary Code	
Mobile Number	
Email ID	

Please read the prospectus before filling up this form.

A. The Company shall not be on risk until the proposal has been accepted by the Company and communications of acceptance has been given to the proposer in writing on full payment of premium.

B. For persons above 50 years of age* or persons having adverse medical history declared in the proposal form will have to undergo, pre-acceptance health checkup at a designated hospital/nursing home. The Divisional Office/Branch Office in the name of hospital/Nursing home will give a referral slip for conducting the pre-acceptance health checkup. The details of the check up to be done are available with the Divisional Office/Branch Office. (*The age shall be relaxed to 60 Y, if a minimum of 3 persons are covered under the policy and one of the member is less than 35 Y of age). List of Medical Tests required are as below.

CBC	Serum HDL
Blood Sugar Fasting & Post Prandial	Routine Urine Examination (RUE)
SGPT	Resting ECG
SGOT	X RAY Chest PA View
Serum Cholesterol	Physician Check Up
Serum Triglycerides	Eye Check Up For Cataract & Glaucoma

C. If other family members residing with proposer i.e. spouse, eligible children, eligible parents etc. are required to be covered, complete details of each person should be furnished. Two Stamp size photograph of each person are to be submitted, one of which is to be affixed on the proposal.

D. Fresh proposal form is required along with pre acceptance medical checkup as mentioned in item (B) above, irrespective of age, when there is break in insurance cover **or** when there is request for enhancement in the sum insured.

E. **Non-disclosure of facts material to the assessment of the risk, providing misleading information, fraud or non-co-operation by the insured will nullify the cover under the policy.**

1. Proposer's Details

Period of Insurance: **From**_____**To** _____

Name of the Proposer (As per the Id Card)		**Date of Birth**	
Gender (M/F/T)	Male/Female/Third Gender	**Educational Qualifications**	
Address for Correspondence			
	Landmark/Area/City/Town:		
	District: State: Pin:		
Email Id		**Occupation**	
Mobile Number		**Family Income**	
Nature of Id	PAN Card/Voter Id/Passport/Any other	**Id Card No**	
PAN Card No		**GST No (If applicable)**	
Assignee/Nominee Name		**DoB of Assignee/Nominee**	
Relationship with Assignee/Nominee			
Appointee Name*		**Relationship with Minor**	

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

2. Name, Address & Contact No. of Family Physician:

Qualification:_____Reg-No: _____

3. Details of Persons to Be Insured:

Floater Sum Insured:_____(Sum Insured Options available are 2L, 3L, 5L, 8L, 10L, 12L, 15L)

Sr. No:	Name of all the persons	Date of Birth	Gender (M/F/T)	Relation (*) with the Proposer	Occupation	Height (in cm)	Weight (in KG)
1							
2							
3							
4							
5							
6.							

(*) Relation as per following table

Self	Spouse	Father	Guardian/Ward	Brother/Sister
Mother	Son	Daughter	Employer-Employee	

4. ABHA NUMBER/ABHA ID*#

Member name	ABHA Number(14 digits)	Consent to share Medical records with Insurers/TPA's through ABHA
		☐ YES/☐NO
		☐ YES/☐NO
		☐ YES/☐NO
		☐ YES/☐NO
		☐ YES/☐NO
		☐ YES/☐NO

 # Disclaimer-Disclosing the ABHA ID in this form will not absolve the Proposer/Members from Disclosure of all Material Facts relating to this Insurance.

***Ayushman Bharat Health Account (ABHA) Declaration** : I/We provide my/ our consent to access my/ our (all insured) medical and personal records/ details, as are available in my/ our Ayushman Bharat Health Account (ABHA) and share the same with Third Party Administrators, Reinsurer (if applicable), Service Provider/s of **The New India Assurance Company Ltd** and/or with any Governmental and/or Regulatory authority for the sole purposes of underwriting my/ our proposal and/ or for checking the authenticity of claims lodged by me/ us and/ or to comply with the applicable Law/ Regulations.

5. Are you at present or have you been at any other time in the past covered under any other Insurance (PA, Cancer Insurance, Hospitalization Insurance or other Medical Insurance). If so, give particulars of:

S. No.	Content	Details
1.	Name of Insurer	
2.	Insurance Scheme	
3.	Policy No.	
4.	Period of cover	
5.	Is there any claim under the previous Insurance (Yes/No)	If Yes, please give the details of such claim and amount received/receivable

6. Any proposal for this Insurance or any other similar insurance refused or cancelled or higher premium charged, either by us or by any other Insurer. If so, give details:

7. Optional Covers (Yes/No):

Name of the person	Optional Cover I- No Proportionate Deduction (Sum Insured: 2 lakhs and above)	Optional Cover II- Maternity Expenses Benefit (Sum Insured: 5 lakhs and above)	Optional Cover III- Revision in Cataract Limit (Sum Insured : 8 lakhs and above)	Optional Cover IV- For Covering Non-Payable Items : Sum Insured 8 lakhs and above)

8. MEDICAL HISTORY: Please answer the following questions with Yes or No (A dash is not sufficient and give full details **in respect of all the persons to be insured**)

Are all the members proposed for insurance in good health while proposing for this insurance? (Yes/No)_____If No, give details of the Illnesses/ diseases for each member.

S. No.	Name of the Person	Nature of illness/pre-existing diseases (*)
1.		
2.		
3.		
4.		
5.		
6.		

9. Have any of the persons proposed for insurance suffered from any illness/disease or had an accident in **the past**? If so, give details as under:

Name of the person	Nature of Illness / Injury & treatment received	Date on which first treatment taken	First treatment completed/is continuing	Name of attending Medical Practitioner with Address & Tel. No.

Note: This information should be given for each of the persons proposed for insurance, if he/she had suffered from any Illness / Injury, please give details separately.

10. Please give details of any knowledge or any positive existence or presence of any ailment, sickness or injury, which may require medical attention? If yes, then give details below:

11. Are there any additional facts affecting the proposed Insurance, which should be disclosed to insurers? If yes, then give details below:

12. Important:

a) The information that you give to us on this proposal form or in any supplementary Information form or documentation supplied by you or on your behalf will influence our decision to offer insurance and the terms upon which to offer it. Further, any policy we issue will be based on what you have communicated to us. It is therefore important that your answer is complete and accurate in all respect.

b) The question in this proposal are indicative rather than exhaustive. You must provide us with all information relevant to the risk to be insured, even if it is not the subject of a question in this proposal. If you are in any doubt as to what information should be given, you should liaise with your Agent/Insurance advisor/ Insurance Company.

c) The list of exclusions/ inclusions and other policy details are indicative, for complete list and comprehensive details kindly refer policy wordings.

d) The Policy shall become voidable at the option of the Company, in the event of any untrue or incorrect statement, misrepresentation, non- description or non-disclosure of material particulars in the Proposal Form/personal statement, declaration and connected documents, or any material fact* information has been withheld by beneficiary or anyone acting on beneficiary's behalf to obtain insurance.

*A material fact will mean and include all important, essential and relevant information, pertaining to the questions made in this proposal form, that are likely to influence company's acceptance or assessment of the proposal.

13. Declaration: I declare that the persons proposed for insurance are my family members and I also declare that

(STRIKE OUT ONE OF THESE TWO STATEMENTS THAT IS NOT APPLICABLE)

i. None of them suffer from any pre-existing conditions **Yes/No**

ii. I have given explicit information of such sickness/disease/injury sustained in the above columns where the information has been sought. **Yes/No**

a. "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.

b. 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 insurance company and that the policy will come into force only after full receipt of the premium chargeable.

c. I/We further declare that I/we 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.

d. I/We declare and consent to the company seeking medical information from any doctor or from a hospital who at any time has attended on the life to be insured/proposer 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.

e. 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 Governmental and/or Regulatory authority."

Signature of Proposer _____

Date: _____/_____/_____ *Place:* _____

Photographs of Insured Persons:

Insured 1	Insured 2	Insured 3	Insured 4	Insured 5	Insured 6

14. Section 41 of Insurance Act, 1938 (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 or 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 in the policy, nor shall any person taking out of renewing or continuing a policy accept any rebate except such rebate as may be allowed in accordance with the prospectus or table of the Insurer.

Any person making default in complying with the provisions of this section shall be punishable with fine which may extend to ten lakh rupees.

15. INTERMEDIARY DECLARATION: I,_____in my capacity as an Agent/ Insurance Advisor/ Specified Person of the Corporate Agent/ Authorized employee of the Broker/Relationship Officer, do hereby declare that I have explained all the contents of this Proposal Form, including the nature of the questions contained in this Proposal Form to the Proposer including statement(s), information and response(s) submitted by him/her in this Proposal Form to questions contained herein or any details sought herein will form the basis of the Contract of Insurance between the Company and the Proposer, if this Proposal is accepted by the Company for issuance of the Policy.

I have further explained that if any untrue statement(s)/ information/response(s) is/are contained in this Proposal Form/including addendum(s), affidavits, statements, submissions, furnished/to be furnished, the Company shall have the right to cancel the policy at its discretion. Further, this declaration does not confirm issuance of policy or assumption of risk thereof.

Name of the Intermediary: **Date:** **Place**

Intermediary Code:

Signature of the Intermediary

16. VERNACULAR DECLARATION

Declaration in case the proposal is filled by other than Proposer (or) the proposer has signed in vernacular language (or) the proposer is illiterate (It is to be certified by someone other than an agent/employee of the company)

(The content of this form and its particulars have been explained by me in vernacular to the Proposer who has understood and confirmed the same.)

Name of the Translator:_____Place:_____ Date: _____

Signature of the Translator _____

Name of the Proposer:_____Place:_____Date: _____

Signature of the Proposer: _____

CHOICE OF TPA.

Third Party Administrator (TPA) means a Company registered with the IRDAI, and engaged by Us for providing health services.

The following TPAs are allotted for servicing your Policy.

1. Assigned TPA:
2. Optional TPA:

If you wish to change your Assigned TPA to Optional TPA, please sign the below declaration and submit it to the Operating Office.

I wish to change my Asigned TPA to Optional TPA i.e. to ----------

Signature of the Proposer. Date

Recommended by the Office In-charge:

Name:

Date:

DO/BO/MO:

Seal:

FOR OFFICE USE ONLY:

Sum Insured: _____

S. No	Name of insured person	Date of Birth	Gender (M/F/T)	Relation	Occupation	Premium
1.						
2.						
3.						
4.						
5.						
6.						
Remarks of Underwriter:					**Total:**	
					GST	
					Gross Total	