THE NEW INDIA ASSURANCE CO. LTD.

REGISTERED & HEAD OFFICE: 87, MAHATMA GANDHI ROAD, MUMBAI - 400 001.

NEW INDIA CRITI PROTECT POLICY

PROPOSAL FORM

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

GUIDELINES FOR COMPLETION OF THE FORM

1. Please answer all questions fully and correctly. Where any question does not apply, please mention clearly that the same is not applicable.
2. Insurance is a contract of Utmost Good Faith requiring the Insured not only to disclose all material facts but also not to suppress any material facts in response to the questions in the proposal form. If any additional fact is material, please disclose it.
3. The Policy shall become void, in the event of any untrue or incorrect statement, misrepresentation, non-description or on non-disclosure in any material particular in the proposal form / personal statement, declaration and connected documents, or any material information having been withheld by the proposer or any one acting on his behalf.
4. Kindly contact the Company's Nodal Office or Agent or Intermediary for any doubts or clarifications on the proposal form.
5. The cover is available for Indian citizens and Indian residents only. Persons of Indian origin but resident of other countries or non-resident Indians (NRI) or OCI are not eligible to take this Policy.
6. Please note that this is a Single Member Policy.

NOTE: The liability of the Company does not commence until this proposal has been accepted and premium is received in full.

Intermediary Name :__________________________________Intermediary Code :______________

Part I - Proposer Details

Name of the Proposer		**Date of Birth**	
Gender	M/F/T	**Mobile Number**	
Email Id:		**GST No (If applicable)**	
Nature of I-Card	PAN Card / Voter Id / Passport / Any other	**Id Card Number**	
Address for Correspondence	**State:** **City:** **Pin code:**		

Part II - Insured details

(To be filled separately for each and every insureds) - All details are mandatory

Name	Mr. Mrs. Miss Surname First Name Middle Name
Relation with the Proposer	Self/Spouse/Children/Parent
Father's /Husband Name	
Nationality	Indian/Others
Current Country & City of Residence with address	City: State: Pin Code:
Contact Number	Landline :
	Mobile :
Nature of Id card and No	Type of Id-card:
	Id Card Number:
Email Id	
Date of Birth (Age limit - 18 to 65 years)	Age : Yrs
Gender	M/F/T
Marital Status	Single/Married/Others
Permanent Account No (PAN No.)	
GST No (If applicable)	
Current Occupation	
Education /Qualification	
Employer/ Business Name	
Designation	
***#ABHA NUMBER/ABHA ID (14 Digits)-** **# Note-**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.	

Part III: Policy & Plan Details:

Plan Option (9 CI/ 18 CI / 25 CI / 41 CI) (Refer to the Annexure for CI Options)	Please specify the option
Are you an Earning Member (Yes/No)	
If Yes, Is it Gainful Employment* or Non-Gainful Employment, Please specify	
What is your Annual Income (INR)	
Sum Insured (INR) Options Available are 5 L to 50 L (in multiples of 5 L)	
Tenure of the Policy (1 Yr or 2 Yr or 3 Yr)	
Policy Period	

Note:

a) *Gainful Employment refers to an employment situation where the employee receives steady work, payment from the employer. This means that income from property rent, shares, investment, interest income etc.. shall not be taken into account under Gainful Employment.

b) For any Sum Assured in excess of INR 25,00,000 Income proof is required. Documents to be submitted for Income Proof:

- ITRS with computation of income for the Latest 2 financial years or,
- Form 16 of latest financial year or,
- Last three months pay slips along with bank statement showing salary credits or,
- Audited P&L account and Balance sheet for the latest two financial years with the share-holding of the applicant

Part IV: Medical Information

A. Have you suffered / are suffering from any disease / illness or currently taking any medication / consultation from any Doctor for the conditions or diseases or illnesses below? **Yes_____No_____**

i. Diabetes Mellitus or Impaired glucose tolerance

ii. Hypertension

iii. Coronary Artery Disease (Angioplasty/Coronary bypass/Heart attack)

iv. Congestive Heart Failure/ Conduction Abnormalities of Cardiac System/ Pacemaker implantation / Congenital Heart Disease / Other Heart ailments

v. Cerebrovascular Accident (Stroke)

vi. Malignancy or Cancer (Leukemia, Sarcoma, etc) Pre malignancy tendencies.

vii. Auto Immune Diseases (Rheumatoid Arthritis, SLE, Ankylosing spondylitis etc.)

viii. Renal Transplant / Congenital disorders of Renal System, Renal failure / Chronic renal disorder / ESRD (End stage renal disorder), Proteinuria

ix. Cirrhosis (Alcoholic/Nonalcoholic)

x. Multiple Sclerosis

xi. Epilepsy

xii. Obstructive lung disease, restrictive lung disease, impairment of lung function

xiii. Hepatitis

xiv. Genetic Disorders

xv. Paralysis

xvi. Inflammatory bowel disease (Crohn's disease Ulcerative Colitis)

xvii. Obese/ Dyslipidemic

xviii.Paraplegic/Hemiplagic/Quadriplegic individuals

xix. Persons with disability

If 'Yes' or You are suffering from 'Any Other' Conditions or diseases or illnesses, indicate in the table below.

S. No.	Name of Disease Suffering from	Name of the medicines	When First treated	Name of attending medical practitioner with address and telephone no.	If fully cured? Answer Yes / No

B. Information for Critical Illness Cover (Medical Questionnaire) - Please write Yes/No

1	Are you now in good health & entirely free from any mental / physical impairments or deformities?	Yes/No
2	Have you ever suffered from or do you suffer from Arthritis, Back Disorder, Diseases of the circulatory system E.g. Heart Disease, Chest pain, High blood pressure, Stroke, Diseases of Arteries / Veins?	Yes/No
3	Have you ever suffered from or do you suffer from Diabetes Mellitus, Cancer or Tumor of any kind, or any diseases of Blood Glands, Digestive System, Liver, Spleen, Ears Eyes, or Skin?	Yes/No
4	Have you ever suffered from or do you suffer from diseases of the Respiratory system (lung diseases) e g, Tuberculosis, Emphysema, Pneumonia?	Yes/No
5	Have you ever suffered from or do you suffer from Asthma?	Yes/No
6	Do you have / had any complaints of difficulty in Breathing, Blood in Sputum or Persistent Respiratory Infections?	Yes/No
7	Have you ever suffered from or do you suffer from any disease of Genitourinary System? / Kidneys?	Yes/No
8	Have you ever been tested positive for HIV/AIDS or Hepatitis B or C, or have you been tested / treated for other sexually transmitted disease or are you awaiting the result of such test?	Yes/No
9	Have you ever suffered from or do you suffer from Diseases of the Nervous system or Mental Disorders e.g., Stroke, Epilepsy, Fits / Fainting attacks, Frequent Headache, Paralysis, Multiple Sclerosis, and Psychiatric Disorders?	Yes/No
10	Do you have any physical disability which is affecting your day-to-day activities?	Yes/No
11	Have you ever taken Narcotics / other habit-forming Drugs or being treated for the same?	Yes/No

12	Have you been treated for Alcoholism related Diseases?	Yes/No
13	Whether Occupation requires significant manual labour / hazardous activities / handling hazardous material / explosives or working at height / with high voltage or heavy machinery or are you an unskilled labourer?	Yes/No
14	Has any of 2 or more family member (Parents and Siblings) ever been diagnosed with diabetes, Hypertension, Kidney Failure, Cancer, Heart Attack or any Hereditary Disorder before the age of 55?	Yes/No
15	Are you currently suffering from any illness, impairment or taking any medication or pills or drugs?	Yes/No
16	During last five years have your undergone or recommended to undergo any hospitalization, operation or any other investigations (excluding checkups for employment/insurance/foreign visit)?	Yes/No
17	Has any application for insurance on your life been postponed, declined, and accepted with extra premium or on other special terms?	Yes/No
18	Do you take part in any hobbies/ activities that could be considered dangerous in any way? E.g. aviation (other than as a fare paying passenger), mountaineering, deep sea diving or any form of racing?	Yes/No
19	Have you suffered from any other Diseases or Ailments not mentioned above?	Yes/No
20	Do you consume tobacco products such as cigarettes, beedi, cigar, pan, Guthkha or any other form of tobacco consumption? If Yes, Please give details below	Yes/No
21	Do you consume alcohol such as Beer, Wine, Spirit or any other form of alcohol intake? If Yes, Please give details below	Yes/No
(For Female Applicants only)		
22	Have you suffered from or suffering from any disease of uterus, breast, cervix, ovaries such as firbroid, cyst, lump etc?	Yes/No
23	Are you currently pregnant?	Yes/No
24	Do you have a history of past Abortion, Miscarriage or complications during pregnancy?	Yes/No

Personal Details / Habits.

- Height (in cm): Weight (in KG):

Smoking		Alcohol		Gutka / Tobacco	
Less than or equal to 10 cigarettes / day	Greater than 10 cigarettes / day	less than or equal to 18 units/week. 1 unit = 30 ml hard liquor/ 1 glass of wine/ 500 ml beer	Greater than 18 units/week. 1 unit = 30 ml hard liquor/ 1 glass of wine/ 500 ml beer	Less than or equal to 5 packets/day. 1 packet= 5gms	Greater than 5 packets / day. 1 packet = 5gms
Yes/No	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No
Duration Since (in Yrs)		**Duration Since (in Yrs)**		**Duration Since (in Yrs)**	

Family Doctor Details

Name : Dr. ____

Contact Nos. :____

Nominee*

Nominee*	Name of Nominee	Relationship with Applicant	DOB	Age	% Share Nominee entitled to
Nominee 1					
Nominee 2					

* Nominee for self has to be one of the below mentioned relations. "Father, Mother, Son, Daughter, Spouse & Others " If Nominee is "Others" please specify :________________________________

*If the Nominee is minor,

- Name of Appointee :______________________Relationship with Minor :______________________

Part V: HEALTH & DATA DECLARATION

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 is 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 intermediary/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.

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

a. 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 authorised 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 insurer and that the policy will come into force only after full payment of the premium chargeable.

c. 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.

d. 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.

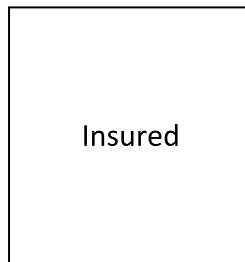
e. I authorize the company to share information pertaining to my proposal including the medical records of the insured/proposer for the sole purpose of underwriting the proposal and/or claims settlement and with any Governmental and/or Regulatory authority

Please Tick ☐ if you wish to receive the physical copy.

By Default Policy documents shall be shared to your Registered Email ID.

Signature of Proposer______________________Date :_____/_____/_________Place : _____________

Photographs of Insured Person:



STATUTORY WARNING

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.

VERNACULAR DECLARATION

Declaration is required in case this 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 Proproser :________________________________Place :__________Date :__________

Signature of the Proproser : ____________________________

FOR OFFICE USE ONLY:

Name	Premium	Loading	Discount	GST	Premium (Inc GST)
Remarks of the underwriter :					

Annexure 1:

Sr. No.	Critical Illnesses	9CI	18CI	25CI	41CI
1	Cancer of Specified Severity	Yes	Yes	Yes	Yes
2	Kidney Failure Requiring Regular Dialysis	Yes	Yes	Yes	Yes
3	End Stage Liver Failure	Yes	Yes	Yes	Yes
4	Major Organ Transplant/Bone Marrow Transplant	Yes	Yes	Yes	Yes
5	Open Heart Replacement or Repair of Heart Valves	Yes	Yes	Yes	Yes
6	Open Chest CABG	Yes	Yes	Yes	Yes
7	Stroke resulting in Permanent Symptoms	Yes	Yes	Yes	Yes
8	Permanent Paralysis of Limbs	Yes	Yes	Yes	Yes
9	Myocardial Infarction (First Heart Attack of Specified Severity)	Yes	Yes	Yes	Yes
10	Multiple Sclerosis with Persisting Symptoms	No	Yes	Yes	Yes
11	Coma of Specified Severity	No	Yes	Yes	Yes
12	Parkinson’s Disease	No	Yes	Yes	Yes
13	Benign Brain Tumour	No	Yes	Yes	Yes
14	Alzheimer’s Disease	No	Yes	Yes	Yes
15	Aorta Graft Surgery	No	Yes	Yes	Yes
16	Deafness	No	Yes	Yes	Yes
17	Loss of speech	No	Yes	Yes	Yes
18	Third Degree Burns	No	Yes	Yes	Yes
19	Motor Neurone Disease with Permanent Symptoms	No	No	Yes	Yes
20	Primary(Idiopathic)Pulmonary Hypertension	No	No	Yes	Yes
21	Loss of Limb	No	No	Yes	Yes
22	Muscular Dystrophy	No	No	Yes	Yes
23	Blindness	No	No	Yes	Yes
24	Major Head Trauma	No	No	Yes	Yes
25	End Stage Lung Failure	No	No	Yes	Yes
26	Systemic Lupus Erythematosis with Lupus Nephritis;	No	No	No	Yes
27	Pneumonectomy	No	No	No	Yes
28	Medullary Cystic Disease	No	No	No	Yes
29	Cardiomyopathy	No	No	No	Yes
30	Encephalitis	No	No	No	Yes
31	Progresive Supranuclear Palsy	No	No	No	Yes
32	Multiple System Atrophy	No	No	No	Yes
33	Pulmonary Artery Graft Surgery	No	No	No	Yes
34	Other Serious Coronary Artery Disease	No	No	No	Yes
35	Apallic Syndrome	No	No	No	Yes
36	Fulminant Hepatitis	No	No	No	Yes
37	Creutzfeldt-Jakob Disease	No	No	No	Yes
38	Aplastic Anaemia	No	No	No	Yes

39	Severe Ulcerative Colitis	No	No	No	Yes
40	Progressive Scleroderma	No	No	No	Yes
41	Bacterial Meningitis	No	No	No	Yes

NEFT details

Mandatory details required to process all payment due in relation to your policy including refunds (if any) and/or claims directly to your Bank account.

I hereby declare that below bank details are correct and should be used to process all payment due in relation to my insurance policy:

Bank account details as provided below and for which I am submitting a cancelled cheque, should be used by the company for electronic fund transfer as mode of payment.(cancelled cheque should be of the same bank account in which the refund needs to be credited directly)

Particulars of Bank account:

Name(As in Bank Account)	
Name of the Bank	
Name of Branch	
Bank Account Number	
MICR No	
IFSC Code	

I agree and undertake to initiate in writing to **The New India Assurance Company Ltd** about any change in the bank account details. I also hereby certify that the particulars furnished above are correct to the best of my knowledge.

Proposer/Policy holder's signature:

Date:

DISCLAIMER: **The New India Assurance Company Ltd.** Shall not be liable to anybody, in any manner, whatsoever if the NEFT transaction does not complete for any reason whatsoever including without limitation – failure on part of the Bank/s involved to perform any of their obligations for aforesaid NEFT transaction or incomplete/incorrect information by Customer/Policy Holder.

Aforesaid NEFT transactions shall be governed by applicable Reserve Bank of India rules, directions & guidelines and shall be subject to participating Bank user terms and conditions related to NEFT facility. **The New India Assurance Company Ltd** shall be indemnified against any loss/damages/claims caused to **The New India Assurance Company Ltd** in carrying out your aforesaid NEFT instructions.

Instructions

- It is important for these electronic payment systems that the policy Holder's name in the Policy must be exactly match with the name in the Bank Account records/details given above.
- In cases where beneficiary's bank account number & name is printed on the cheque, bank attestation is not required. For all other cases bank attested NEFT mandate is required
- The customer who is willing to transfer the funds will be required to provide the 11 digits valid IFSC Code, which is applicable to NEFT only.(a number allotted to each participating bank branch) of the branch where the funds need to be transferred.
- Cancelled cheque should be attached along with the NEFT format.
- In case of cancelled bank cheque does not bear account holder's name, please provide photocopy of bank statement / passbook with latest entries updated or else Bank attestation is required.
- NEFT Form needs complete in all respect.