THE NEW INDIA ASSURANCE CO. LTD.

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

NEW INDIA MEDICLAIM POLICY

PROPOSAL FORM

URN: (NIA/Health/24-25/UK)

Agency Details:

Name of the Intermediary	
Intermediary Code	
Mobile Number	
Email ID	

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.

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 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). 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.

If other family members residing with proposer i.e. spouse, eligible dependent children, dependent 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.

Fresh proposal form is required along with pre acceptance medical checkup, irrespective of age, when there is break in insurance cover.

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

Name	
Gender(Male/Female/Third Gender)	
Occupation	
Educational qualifications	
Family Monthly Income	
Passport No / Pan card No / Driving License / Any Other	
Landline / Mobile Number	
Residential Address (Permanent)	
Address for Correspondence	
Email ID	
Name of Family Physician	
Nationality (India / Others), If others pleasespecify the Nationality	

2. 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.	Claim Amt. Recd./receivable	

3. 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:

4. DETAILS OF PERSONS TO BE INSURED:

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

(*) Relation as per following table

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

5. Nominee Details

S. No.	NAME	Relation	Date of Birth	Appointee Name* (If the Nominee is minor)	Relationship with Minor (Nominee)	% Share nominee is entitled to*

***Note - If only one nominee is mentioned insurer will consider his share is 100%**

6. ABHA NUMBER / ABHA ID*

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

7. 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)

I. Are all the members proposed for insurance in good health and free from physical and Mental disease or infirmity? If no, give details of the illnesses/ diseases for each member. **Select the illness/conditions from the table given below:**

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

***Table for selecting Pre-Existing Disease (PED)**

Spinal or Vertebral Disorders	Cataract	Breathing Disorders
Uterine Bleeding	Arthritis and Joint disorders	Gastritis and Duodenitis
Kidney disorders	Headache Syndromes	Hernia
Enlargement of Prostate (BPH, enlargement of prostate)	Thyroid and Other Hormonal Disorders	E.N.T. Disorders
Cholelithiasis	Any Malignancy	Hemorrhoids
Stroke and T.I.A.	Ischaemic Heart Disease	Any Other (Please specify)

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

Name of the person	Nature of illness /disease/injury & treatment received	Date on which first treatment taken	First treatment completed / is continuing	Name of attending medical practitioner / surgeon with his address & tel. Nos.

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

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

IV. 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:

V. 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-Voluntary Co-pay	Optional Cover V-Voluntary Co-pay - Non-Medical Items (Consumables) - (Sum Insured: 8 lakhs and above)

8. Riders Table(YES/NO)

Name of Insured						
Critical Illness Rider						
Pre and Post Hospitalization Rider						
Durable Medical Devices Rider						

9. Term of Insurance: ☐ 1 Year
☐ 2 Years
☐ 3 Years

Period of Insurance : From_____To _____

10. Zone Opted: ☐ Zone 1 ☐ Zone 2.

Zone 1	Maharashtra and Gujarat
Zone 2	Rest of India

- Insured opting for Zone 1 can avail treatment anywhere in India and No Co-pay shall be applicable.
- Insured residing in zone 2 will be allowed to opt for the zone 1 and the premium will be calculated as per selected zone.
- The condition of 20% Co-payment will be applicable, if the insured from zone 2, gets treated in zone 1.
- Co-Pay shall not be applicable for immediate hospitalization arising out of Accident.
- Co-Pay shall also not be applicable for Illness or Treatments having sub-limit

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

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

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 ☐ ☐

ii. I have given explicit information of such sickness/disease/injury sustained in the above columns where the information has been sought. ☐ ☐

1. "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.

2. 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.

3. 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.

4. 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.

5. 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

Section 41 of Insurance Act, 1938

Prohibition of Rebates

1. 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.

2. **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 :_____

3. VERNACULAR DECLARATION

Declaration in case the proposal is filled by other than the Proposer (or) the proposer has signed in vernacular language (or) the proposer is illiterate (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 :_____

FOR OFFICE USE ONLY:

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

The New India Assurance Company Limited

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. Please select any one of the below options 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 mentioned on the cheque* being submitted along with the proposal form towards premium payment for insurance policy should be used by the company for electronic fund transfer as mode of payment.

☐ 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.
- In case the premium payment cheque does not have all the details required for electronic fund transfer , please fill the above table.