THE NEW INDIA ASSURANCE CO. LTD.

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

PARIPOORNA MEDICLAIM AYUSH BIMA

(HEALTH INSURANCE COVER FOR CGHS BENEFICIARIES)

(UIN : NIAHLIP26073V012526)

Waiver of Pre Acceptance Disease (PED) / Waiting Period

- Name of the Proposer: ……
- CGHS Card No.: ……
- Department: ……
- Details of the Insured Member:

Name of the person	Date of Birth	Sex (M/F /T)	Relation with the Proposer	Occupation	Height (in cm)	Weight (in KG)	CGHS Beneficiary (Yes / No)	CGHS card No. (If member is CGHS beneficiary)

The proposer is requested to fill the following details in this form to ensure his/her eligibility for waiver of PED/ Waiting Period

Medical History: To be completed by the Medical Practitioner/ Employer / CGHS: Please answer the following questions with Yes or No and Description as mentioned (A dash is not sufficient and give full details):

Sr.no	Medical Questioner	Yes/No	Description
1	Is the proposer currently in good health **and** free from **physical** and mental disease? (if No, please describe)		
2	Is the proposer on any medication for any health conditions? (if YES, please describe the conditions and the time since when you are on medication/s.)		
3	Has the proposer ever suffered from any illness **or** disease/medical condition up to the date of **making this** proposal? (if YES, please describe the incident along with date and time of the incident.)		

4	Does the proposer **have** any physical defect or deformity? (if YES, please describe. Also mention whether it's congenital or not.)		
5	Has the proposer ever been admitted to any hospital, nursing home, or clinic for treatment or observation? (if YES, please describe the incident along with date and time of the incident.)		

If the answer is 'yes' to any of the questions in point (2.),(3.),(4.),(5.) above, then please give details as under:

Nature of Illness/disease/injury & treatment involved	Date of which first treatment taken	First treatment completed/is continuing	Name of the attending medical practitioner/surgeon with his address & telephone no

Name of the Medical Practitioner / Competent Authority (CGHS / Employer):

……

Designation:……

Address:……..

Signature:

Stamp: