THE NEW INDIA ASSURANCE CO. LTD.

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

PROPOSAL FORM FOR SENIOR CITIZENS MEDICLAIM POLICY

Please read the prospectus before filling up this form.

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

B) Proposers must undergo a pre-acceptance health check up at a hospital/nursing home designated by the Company.

C) Complete details of all persons to be covered must be furnished along with two stamp size photographs of each person, one of which is to be affixed on this proposal form.

D) Fresh proposal form along with pre acceptance medical check up is required in case of any break in insurance.

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. NAME OF PROPOSER : Mr./Mrs._____

2. RESIDENTIAL ADDRESS : _____

   _____

   Tel. No. :_____ Fax No. :_____

   E-Mail :_____

3. Occupation: (please Tick)
   - ❑ Professional/Administrative/Managerial
   - ❑ Business /Trader
   - ❑ Clerical, Supervisory and related worker
   - ❑ Hospitality and Support Worker
   - ❑ Production Workers Skilled and non-Agricultural Labourer
   - ❑ Farmer and Agricultural Worker
   - ❑ Police/Para Military/Defence
   - ❑ Housewife
   - ❑ Retired Person
   - ❑ Student – School and College
   - ❑ Any Other

4. Average Monthly Income Rs._____ Income Tax PAN No.:_____

5. NAME, ADDRESS & TEL. NO. : OF FAMILY PHYSICIAN _____

   _____

   QUALIFICATION :_____ REGN. NO :_____

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

Content	Details
Name of Insurer	
Insurance Scheme	
Policy No.	
Period of cover	
Claim Amt. Recd./receivable	

7. Any proposal for this Insurance or any other similar insurance refused or cancelled or higher premium charged. If so, give details:

8. DETAILS OF PERSONS TO BE INSURED:

Sr. No.	Name of all the persons	Date of Birth	Sex (M/F)	Relation withthe Proposer	Sum Insured selected	History of (Pls. Tick)		Signature
						Diabetes	Hyper tension	
1								
2								
3								

(*)Relation as per following table

Self	Spouse

9. Nominee Details

Sr. 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%**

13. 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

 # 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.

11. 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 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:**

Sr. No.	Name of the Person	Nature of illness / pre-existing diseases **(*)**

*Table for selecting Pre-Existing Disease (PED)

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

10) Has any of the persons proposed for insurance has 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 / disease / injury & treatment received (please refer	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 any of the persons proposed for insurance, if he/she had suffered from any illness/disease injury, please give details separately.

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

12) 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:

13) Name of the Assignee_____Relationship _____

14) Period of Insurance : Twelve months w.e.f._____To_____

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

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

16) 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.

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

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:

1	2

18) **Agent 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 Agent :_____Date :_____Place :_____

Agent Code :_____

Signature of the Agent :_____

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 of any person to take out or renew or continue an insurance in respect of 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 on the policy nor shall any person taking out or renewing or continuing a policy except any rebate except such rebate as may be allowed in accordance with the prospectus or tables of the insurer.

2) Any person making default in complying with the provisions of this Section shall be punishable with fine, which may extend to Ten Lakh rupees.

FOR OFFICE USE ONLY:

Sr. No.	Name of insured person	Date of Birth/ Age	S.I. (Rs.)	Loading for diabetes and hypertension	Discounts, If any	Premium
1						
2						
3						
4						
5						
6						
Remarks of Underwriter:				**Total:**		
				GST		
				Gross Total		

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.