THE NEW INDIA ASSURANCE CO. LTD.

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

PROPOSAL FORM OF NEW INDIA TOP UP MEDICLAIM POLICY

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. No Pre-acceptance Health Check-up for persons above 50 years of age, if the person has Health insurance policy from our company and there's no claim for previous two years.

c. For persons above 50 years of age and policy from other insurer or no policy or claim in previou two years, will have to undergo, pre-acceptance health check-up 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 check-up. The details o the check up to be done are available with the Divisional Office/Branch Office.

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

e. Fresh proposal form is required along with pre acceptance medical check-up 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.

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

1. Name of proposer : _____

2. Residential Address : _____

_____

Tel. No. :_____Email :_____

3. Occupation: (Please tick)

Professional/Administrative/Managerial	Farmers and Agricultural Workers
Business /Traders	Police / Para Military / Defence
Clerical, Supervisory and related workers	Housewives
Hospitality and Support Workers	Retired Persons
Production Workers, Skilled and non-Agricultural Labourers	Students - School and College
	Any Other

4. Average Monthly Income :_____PAN No.:_____

5. Name, Address & Tel No. of family physician _____

_____

Qualification :_____Regn. No :_____

6. DETAILS OF PERSONS TO BE INSURED:

S. No.	Name	DOB	Sex (M/F)	Relation	History		Signature
					Diabetes	Hyper tension	
1.							
2.							
3.							
4.							
5.							
6.							

7. 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.

PHOTOGRAPHS OF INSURED PERSONS:

Photograph	Photograph	Photograph	Photograph	Photograph	Photograph

8. Policy to be issued on:_____Individual Basis / Family Floater Basis _____

9. If on Family Floater basis, please choose coverage type:

   (Refer to prospectus for definition of family; Parents can be covered in the same policy) Self, Spouse, Children & Parents

   Indicate options : A / B / C / D / E / F / G

10. If on Individual basis, please choose coverage type for each individual

S.No.	Name	Relation	Coverage Type
1.			
2.			
3.			
4.			
5.			
6.			

11. Period of Insurance : From_____to_____(Midnight)

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

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

14. **Are any of the Insured at present or have been at any other time in the past, covered** (Please note that this information is required to decide the coverage of Pre- Existing Disease in this policy. This information may be cross-verified at a later date)

I. **Under any other Insurance** (Cancer Insurance, Hospitalization Insurance or other Medical Insurance), If so, Give particulars of current or expiring policy as well as for the previous four years

Insurer	Policy No.	Policy Period	Sum Insured	PED, if any	TPA

Date of first coverage which has since been renewed continuously without break or within grace period :_____

II. **Under any Medical expenses Reimbursement Scheme:**_____Yes /_____No
Please provide following details

i. Scheme provided by: Employer / Other
ii. Name of the employer:
iii. Persons covered:
iv. Expenses Reimbursed:

v. Amounts:

15. Claim amount received / receivable in preceding four years including expiring policy:

Insurer	Policy No.	Hospitalization Period	Illness	Claimed Amount	Amount Receivable	TPA

16. Has any Proposal for this Insurance or any other health insurance been refused or cancelled or higher premium charged. If so give details:

17. Are all the insured persons in good health and free from Physical and mental diseases or infirmity or medical complaints (Adverse Medical History)? Yes / No

18. If not in good health give full details

[All the person/s who is / are not in good health has / have to undergo Medical Examination]

S. No.	Name of the Insured	Nature of illness	Date of first Treatment	Name of Doctor with Ph No & Address	Whether fully cured

19. Are you an employee of NIA / NIC / UIIC / OIC / GIC Yes No

If Yes, Please Furnish SR No._____and Name of Company_____

20. **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 Illness / Injury sustained in the above columns where the information has been sought. Yes No

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."

Date : _____

Place :_____ Signature of the Proposer

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:

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

DETAILS OF INTERMEDIARY (AGENT / BROKER / DIRECT)		
Name	:	
Code	:	

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.