. **THE NEW INDIA ASSURANCE CO. LTD.**
Regd. & Head Office: 87, M.G. Road, Fort, Mumbai- 400 001

OVERSEAS TRAVEL EASE POLICY (BUSINESS & HOLIDAY)
PROPOSAL FORM (NIA/Health/21-22/BH)

Name of the Intermediary:		Mobile Number:	
Intermediary Code:		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.

Complete details of the person to be covered should be furnished. Two Stamp size photograph of each person are to be submitted, one of which is to be affixed on the proposal.

Non-disclosure or misrepresentation of your health condition/medical information in the assessment of risk and acceptance of proposal, and non co-operation will render the insurance contract void ab initio.

General and Important Information

A. Proposal Form is to be submitted in Original with 2 Copies
B. Please make sure that you read and fully understand this document before you travel from the Republic of India.
C. Failure to follow the instructions given could result in rejection of any claim that might be made
D. Overseas Travel Ease (Business & Holiday, provides coverage for expenses necessarily incurred for immediate treatment of Illness, Diseases contracted or Injury first sustained during the period of Overseas Travel subject to policy terms and conditions.
E. Neither the Insurer nor the Overseas Claims Service Provider shall be responsible for the availability, quality, or results of any medical treatment or the failure of the Insured to obtain medical treatment.
F. Criteria for medical examination:

Age	Condition	Medical Checkup
< 60 Years	No PED	Not Required
< 60 Years	PED	Required
61 Years & Above	PED/No PED	Required

G. **Following Pre Acceptance Medicals to be done and the questionnaire to be filled in (As per Annexure 1) by the doctor conducting the said medical examination.**

ECG Report	Chest X-Ray	CBC	Fasting blood
RUA (Routine urine analysis)	Abdominal and pelvic USG.	Any other Medical report required by the Company	

H. The Following Plans are available under the Policy for Worldwide cover Including & Excluding (USA & Canada)

Plan	Basic	Economy	Advanced	Elite	Supreme
Sum Insured	$ 25,000	$ 50,000	$ 100,000	$ 250,000	$ 500,000

I. **Sum insured offered for Persons of 61 years of age and above**

Age	Sum insured offered in USD	Limit for Any one Incident in USD
71 to 80 years	Up to $ 250,000	$ 50,000
81 Years & above	Up to $ 50,000	$ 20,000

Age of insured	PED / No PED	Sum insured offered in USD
61 to 70 Years	No PED or No Co-Morbidities	Up to Maximum of $ 500,000
	With PED or Co-Morbidities	Up to Maximum of $ 250,000

J. **Proof of Identity** (Driving License / Passport / PAN Card / Voter Id / Any Other Acceptable Proof of identity approved by Govt of India)

Proof of identity of the member to be covered should be submitted. For this purpose self-attested copies of any one of the above documents are acceptable.

K. **Details of the person to be covered**

Name of the person to be covered (As stated in the Passport)				
Gender (M/F/T)	Male/Female/Third Gender	**Date of Birth:**		
GST No (If applicable)				
Residential Address (Permanent)				
	Landmark/Area/City/Town:			**Pin:**
	District:	**State:**		
Email ID of the insured		**Mobile/contact no of the insured**		
Overseas Address/contact details for Correspondence (optional)				
	Landmark/Area/City/Town:			**Pin:**
	District:	**State:**		**Mobile Number**
Name of the Assignee/Nominee		**Relationship with the Assignee/Nominee**		

L. **Plan and Sum Insured Opted**:

Travel	Plan opted (Yes/No)	Sum insured (USD)
Excluding USA& Canada		
Including USA & Canada		

M. **Purpose of Visit (Business/Holiday):**

N. **Proposed Date of Departure from Republic of India i.e. First Day of Insurance:**

O. **Insurance required for (Number of Days):**

P. **Passport Number:** **Date of Expiry:**

Name of Passport Issuing Authority:

Q. **Name, Registration No, Address & Telephone No of the Family Physician:**

R. **Medical History: To be completed by the Proposer:** Please answer the following questions with Yes or No (A dash is not sufficient and give full details)

Sr.no	Medical Questioner	Yes/No
1	Are you currently in good health and free from Physical and mental disease	
2	Are you on any medication for any health conditions	
3	Have you ever suffered from any illness or disease/medical condition upto the date of making this proposal	
4	Do you have any physical defect or deformity	
5	Have you ever been admitted to any hospital/nursing home / clinic for treatment or observation	

S. **If the answer is 'yes' to any of the questions 'R' 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

T. **Whether you have any active retail health policy of New India? – YES ☐ /NO ☐**

IF Yes ,

Policy Number of Active Retail Health Policy—	
Policy Holder Code-	

U. **ABHA** NUMBER/ABHA ID***(**If you have **)**

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

***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

V. **Proposer Declaration**

(STRIKE OUT ONE OF THESE TWO STATEMENTS THAT IS NOT APPLICABLE)

I am not suffering from any pre-existing conditions	YES	NO
I have given explicit information of such sickness/disease/injury sustained in the above columns where the information has been sought.	YES	NO
I am not travelling against the advice of a physician	YES	NO
I am not on the waiting list of any medical treatment	YES	NO
I am not travelling for the purpose of obtaining medical treatment	YES	NO
I have not received a terminal prognosis for a medical condition before this day	YES	NO

(In case the person to be covered is a minor, the above declaration should be given by the proposer for the proposed minor inserting the relationship of the person to be covered)

Signature of Proposer_____ **Date:** _____/_____/_____

Place: _____

W. **BANK** ACCOUNT 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.

X. **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.

Y. **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.

Z. **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: _____

Photograph of Insured Person:

Insured

AA. **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

BB. **VERNACULAR DECLARATION**

Declaration in case the proposal is filled other than the Proposer/the proposer sign in vernacular language/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: _____

CC. **FOR OFFICE USE ONLY:**

S. No	Name of Insured person	Date of Birth	Sex(M/F/T)	Sum Insured	Gross Premium
1.					
Remarks of Underwriter:				**Total:**	
				GST	
				Net Premium	

Annexure 1

BENEFIT STRUCTURE

Overseas Travel Ease Policy (Business & Holiday)					
Including / Excluding USA & CANADA option					
Coverages / Plan	**Limits of Liability**				
	Basic	**Economy**	**Advanced**	**Elite**	**Supreme**
Medical Expenses	$25,000	$50,000	$1,00,000	$2,50,000	$5,00,000
Deductible for Medical Expenses	$100	$100	$100	$100	$100
Hospital cash for Critical ailments for hospitalization beyond 2 days. (For a maximum of 5 days)	NIL	NIL	25$ per day	50$ per day	75$ per day
Emergency Dental Care	$100	$200	$300	$400	$500
Personal Accident	$2,500	$5,000	$10,000	$25,000	$50,000
Repatriation of Mortal Remains	$1,250	$2,500	$5,000	$12,500	$25,000
Loss of Checked in Baggage	$300	$400	$600	$800	$1,000
Delay in Baggage over 12 hours (outbound flights)	$25	$50	$100	$150	$200
Loss of Passport	$200	$200	$250	$300	$300
Personal Liability	$12,500	$25,000	$50,000	$1,25,000	$2,50,000
Deductible for Personal Liability	$200	$200	$200	$200	$200
Emergency Financial Assistance	$50	$100	$150	$200	$300
Hijack Allowance (over 12 hours)	$100 per day (max 7 days)	$100 per day (max 7 days)	$100 per day (max 7 days)	$100 per day (max 7 days)	$100 per day (max 7 days)
Trip Cancellation/Interruption	$200	$300	$400	$500	$750
Missed Connection	$200	$300	$400	$500	$750

Medical Checkup Form (Annexure 2)

1. Name of the Insured:
2. Date of Birth:
3. Any past history of disease, operation, accidents, investigations etc..:
4. General Examination:
5. Systemic Examination:
6. Electrocardiography

   Does the attached report in your professional opinion show any abnormalities if so, please describe :

   a. Does the abnormality represent a current illness or disease, which may possibly require medical treatment during Insured's forthcoming trip?

   b. Does the Insured now or did he/she in the past require medication for this abnormality?

   c. Please describe any treatment taken by the Insured in the past or being taken at present

   d. Do you recommend Stress Test ? If so please obtain the report on such test.

7. Does the Blood/Urine Strip Test show any sugar?
8. Does the attached reports in your professional opinion show any abnormalities if so, please describe.

9. Based on the reports, do you consider that Insured fit to travel anywhere abroad?

Signature and stamp of the Doctor:

Name of the Doctor:

Qualification: **Address & Contact No:**

Note: The above report should be accompanied by the investigation reports as stated under point G