



Relationship Beyond Insurance

For Office Use Only :			For Agent Use Only :					
Scrutiny No.	Receipt No.	Policy No.	Loan Account Number	IMD Code	Sub IMD Code	IMD Name	Mobile No.	Emp/LG Code
CRITICAL ILLNESS - PROPOSAL FORM								

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Instructions For Filling Up The Form:-

1. Please answer all questions in BLOCK letters

2. The Liability of the Company does not commence until this Proposal has been accepted by the Company and premium has been paid

3. This Proposal will be the basis of any subsequent policy that we issue to you. It is therefore essential that you provide all the information in this Proposal FULLY AND ACCURATELY and that you provide us with any and all additional information relevant to risk to be insured or our decision as to acceptance of the risk or the terms upon which it should be accepted

Proposer Details							
1) Full Name: Title	First Name						
Middle Name	Surname						
2) Are you an existing Bajaj Allianz Customer: Yes / No If yes, please mention the Polic	y No: OG						
3) Gender: Male 🗍 Female 🗍 Other 🗍	4) Date of Birth : DDDMMMMYYYYYY						
5) PAN No.	6) UID/Unique ID :						
7) Bajaj Allianz Employee Code, if Proposer is BAGIC/BALIC Employee:							
8) Marital Status: 🗌 Married 🗌 Single 🗌 Divorced 🗌 Widowed	9) No. of Children Sons Daughters						
10) Occupation : Business Salaried Professional Student Ho 11a) Permanent / Residential Address :	use Wife Retired Others						
House No & Name							
Landmark/Locality							
Road/Area Name I	City						
State	Pin Code						
11b) Correspondence Address : (All the communications will be sent to the below addre	uss)						
House No & Name							
Landmark/Locality							
Road/Area Name	City						
State	Pin Code						
Telephone (Res.)	phone (Office)						
Mobile Number							
12) Educational Qualification: Matriculate Under Graduate Graduate	Post Graduate Professionally Qualified						
13) Family Monthly Income: Up to Rs. 20,000 Rs. 20,001 to Rs. 50,000	Rs. 50,001 to Rs. 1 lakh Above Rs. 1 lakh						
14) In case of any Offer, you would prefer to be contacted by: Phone Email	15) Nationality						
Details of the nercons to be incured							
Details of the persons to be insured							
Sr NoNameDOB (dd/mm /yy)Gender 	Vt Occupation Relation Premium Nominee Relationship of Nominee						
Section-II Insurance Information							
Critical Illness benefit applied for Rs							
Do you have other current or pending critical illness Insurance with BAGICL ?	Yes No						
If yes Policy No							
Do you have other current or pending critical illness Insurance with another Company?							
If yes:							
Name of Institution : Year D D M Y							
Has any proposal for Life, Accident, Disability cover, Critical Illness or any other Health-Related							
Insurance on your life ever been postponed, declined or accepted on special terms?							
If yes, give details including amount applied for :							

S	ecti	on-III Health Status	
PL	EAS	E ANSWER ALL QUESTIONS BY CHECKING EITHER THE YES OR NO BOX	
1.	Are	e you now in good health and entirely free from any mental or physical impairments or deformities?	Yes No
2.	He	ight(Cm.) Weight(Kg.) How much weight have you lost or gained over the last 12 months?(Kg.)
	Rea	ason for weight change:	
3.		ive you ever suffered or do you now suffer from:	
	a)	Diseases of the circulatory system (e.g. heart trouble, chest pain, rheumatic fever, high blood pressure, diseases of the arteries and veins)?	Yes No
	b)	Diseases of the respiratory system (e.g. tuberculosis, asthma, persistent cough, pneumonia or emphysema)?	Yes No
	c)	Diseases of the genito-urinary system (e.g. infections of the kidneys, urinary or genital organs, renal stones, venereal disease)?	Yes No
	d)	Diseases of the gastrointestinal system (e.g. digestive disorders, gastric or duodenal ulcer, hepatitis B, hepatitis C or other disorders of the liver, disorders of the gall bladder)?	Yes No
	e)	Diseases of the nervous system or mental disorders (e.g. stroke, epilepsy, fits or fainting attacks, frequent headaches, nervous breakdown, depression or other mental or psychiatric disorder)?	Yes No
	f)	Diabetes mellitus, cancer or tumour of any kind, or any diseases of the blood, glands, spleen, ears, eyes or skin?	Yes No
	g)	Unexplained night-sweats and/or loss of weight, persistent fever, chronic or recurrent diarrhea, unexplained infections or swollen glands?	Yes No
	h)	Any other diseases or ailments not mentioned above?	
4.		re you or any of your immediate family members (father, mother, brother, or sister) have/had cancer, heart attack, or ske and at what age? Prior to age 60?	Yes No
5.	Hav	re you ever had or been advised to have hospital treatment or surgery?	Yes No
6.		re you ever had or been advised to have a blood test for AIDS or an AIDS-related condition or have you ever been refused blood donor?	Yes No
7.		he past 5 years, have you consulted a physician for any reason or have you had any investigation such as blood or urine tests, ays, electrocardiograms, ultra sonograms, CT scans or biopsy, other than for routine employment or immigration purposes?	Yes No
8.	Hav	e you ever received or do you now receive any personal accident, disability benefit, or disability-related payments?	Yes No
9.	Are	you at present or any time in past were on any medication, special diet, or treatment?	Yes No
10.		re you ever taken narcotics or other habit forming drugs or been treated or advised in connection with your alcohol consumption he taking of drugs?	Yes No
11.		you participate or do you intend to participate in any hazardous sports or activities such as motor sports, climbing, parachuting, Ig-gliding, or aviation except as a fare-paying passenger?	Yes No
12.		you pregnant (for female only)? If yes, please state how many months. Please state if you had any pregnancy related nplication during your previous pregnancy/delivery?	Yes No
13.		re you smoked or used any substance or product containing tobacco, nicotine or marijuana? es, please state duration and average daily consumption and type:	Yes No
14.	Nan	ne and address of your regular medical consultant:	

If you answered "yes" to any of the questions numbered 1 to 13 (in Section 3 Health Status), please give complete details (including dates, duration and treatment, names and addresses of physicians) on the reverse of this form and include your signature and the date.

*DECLARATION

1.	I 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
2	true and complete in all respects to the best of my knowledge and that I am authorised to propose on behalf of these other persons. 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 insurer
۷.	and that the policy will come into force only after full payment of the premium chargeable

3.	I further declare that I 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

- I declare that I consent to the company seeking medical information from any doctor or hospital who/which at any time has attended on the person to be 4. insured/proposer or from any past or present employer concerning anything which affects the physical or mental health of the person to be insured/proposer and seeking information from any insurer to whom an application for insurance on the person to be insured /proposer has been made for the purpose of underwriting the proposal and/or claim settlement.
- 5. I authorize the company to share information pertaining to my proposal including the medical records of the insured/proposer for the sole purpose of underwriting the proposal and/or claims settlement and with any Governmental and/or Regulatory authority.

Signature of Proposer

Proposed Policy Period: From: DD/MM/YYYY , To: DD/MM/YYYY	Date:	D	D	Μ	M	Y	Y	Y	Y	

INSURANCE ACT, 1938 SECTION 41 - 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 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 a policy accept any rebate, except such rebate as may be allowed in accordance with the published prospectus or tables of the insurer. ANY PERSON MAKING FAULT IN COMPLYING WITH THE PROVISIONS OF THIS SECTION SHALL BE PUNISHABLE WITH FINE WHICH MAY EXTEND TO RUPEES TEN LAKH. * Please read declaration wordings carefully before signing the proposal form.