BAJAJ Allianz

Relationship Beyond Insurance

PF000735596

For Office Use Only:

Scrutiny No.	Receipt No.	Policy No.

For Agent Use Only:

IMD Code	IMD Name

HEALTH GUARD : PROPOSAL FORM

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 the Company issues to you. It is therefore essential that you provide all the information in this Proposal FULLY AND ACCURATELY and that you provide the Company with any and all additional information relevant to risk to be insured or its 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: Y es / No If yes, please mention the Policy No: OG_____
3. Gender: ☐ Male ☐ Female ☐ Other 4. Date of Birth D D M M Y Y Y Y
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 ☐ House Wife ☐ Retired ☐ Others

11. a) Permanent / Residential Address		11 b) Correspondence Address: (All the communications will be sent to the below address)	
House No.		House No.	
House Name		House Name	
Landmark/Locality		Landmark/Locality	
Road/Area Name		Road/Area Name	
City/District		City/District	
State		State	
Pin Code		Pin Code	
Tel.		Tel.	
Mobile		Mobile	
Email		Email	

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 _____ 16. Policy Period: ☐ 1 year ☐ 2 year ☐ 3 year
17. Plan: ☐ Silver ☐ Gold
18. Sum Insured Options
    a) Health Guard Individual Sum insured: ☐ Please mention the member wise sum insured in the member details table
    b) Health Guard Family Floater Sum Insured – please select the sum insured option from below
    ☐ 1.5 lacs ☐ 2 lacs ☐ 3 lacs ☐ 4 lacs ☐ 5 lacs ☐ 7.5 lacs ☐ 10 lacs ☐ 15 lacs ☐ 20 lacs ☐ 25 lacs ☐ 30 lacs ☐ 35 lacs ☐ 40 lacs ☐ 45 lacs ☐ 50 lacs
19. **Premium Payment Zone: ☐ Zone A ☐ Zone B**
    There are Two Zones for Premium payment
    Zone A: "Following cities has been clubbed in Zone A:-
    Delhi / NCR, Mumbai including Navi Mumbai, Thane and Kalyan, Hyderabad and Secunderabad, Bangalore, Kolkata, Ahmedabad, Vadodara and Surat.
    Zone B: Rest of India apart from Zone A cities are classified as Zone B.
    Note:-
    Policyholders paying Zone A premium rates can avail treatment allover India without any co-payment.
    But, those, who pay zone B premium rates and avail treatment in Zone A city will have to pay 20% co-payment on admissible claim amount. This Co – payment will not be applicable for Accidental Hospitalization cases."
    Policyholder residing in Zone B can choose to pay premium for Zone A and avail treatment all over India without any co-payment.
20. Co pay Discount: ☐ Yes ☐ No (If yes please choose from below options)
    ☐ 10% ☐ 20%
    Note:If opted voluntarily by the Insured then Insured will be eligible of additional 10% or20% discount respectively on the policy premium. In case of a claim has been admitted under In-patient Hospitalisation Treatment then, the insured person shall bear 10% or 20% respectively of the eligible claim amount payable under this cover.

21. DETAILS OF PERSONS TO BE INSURED

Member Details	Relationship with Proposer	Date of Birth DD/MM/YYYY	Age	Height	Weight	Gender (M/ F)	Sum Insured	Nominee	Nominee Relationship with Insured

22. Has any of the persons to be insured suffer from/or investigated for any of the following?
Disorder of the heart, or circulatory system, chest pain, high blood pressure, stroke, asthma any respiratory conditions, cancer tumor lump of any kind, diabetes, hepatitis, disorder of urinary tract or kidneys, blood disorder, any mental or psychiatric conditions, any disease of brain or nervous system, fits (epilepsy) slipped disc, backache, any congenital/ birth defects/ urinary diseases, AIDS or positive HIV, If yes, indicate in the table given below. ☐ Yes/ ☐ No
If yes please provide details

23. Do you or any of the family members to be covered have/had any health complaints/met with any accident in the past and have been taking treatment/ hospitalization? (Please provide details in the table given below)

Sr. No	Name of the person	Name of the Illness/injury suffered / suffering in the past	Treatment details	Date first treated	Current Status of the Illness/Diseases/Injury

To support our Go Green initiative, we will send the policy copy on your email. This is a digitally signed valid document.
Please confirm if you still want to receive the physical hard copy of insurance policy ☐ **Yes** ☐ **No**

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 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.
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 insurer 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.
4. 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 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.

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

Signature of Proposer

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.