BAJAJ | Allianz

Bajaj Allianz General Insurance Co. Ltd. G.E. Plaza, Airport Road, Yerawada, Pune - 411 006.

For Office Use Only:

| Scrutiny No. | Receipt No. | Policy No. |
|---|---|---|
| | | |

For Agent Use Only:

| Emp/LG Code | Loan Account Number | IMD Code | Sub IMD Code | IMD Name | Mobile No. |
|---|---|---|---|---|---|
| | | | | | |

# EXTRA CARE 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 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 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

House No. House Name

Landmark/ Locality

Road/ Area Name

City/District

State Pin Code

Tel.

Mobile

Email

## 11 b) Correspondence Address: (All the communications will be sent to the below address)

House No. House Name

Landmark/ Locality

Road/ Area Name

City/District

State Pin Code

Tel.(Res.)

Tel.(Office)

Mobile Number

E-Mail

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) Plans : ☐ Plan A – Sum Insured 10Lacs – deductible 3Lacs ☐ Plan B – Sum Insured 12Lacs – deductible 4Lacs ☐ Plan C – Sum Insured 15Lacs – deductible 5Lacs

## Details of the persons to be insured

| Sr No | Name | DOB (dd/mm /yy) | Age | Gender (M/F) | Ht | Wt | Occupation | Relation | Premium | Nominee | Relationship of Nominee |
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17) Period of Insurance: From D D M M Y Y Y Y To D D M M Y Y Y Y

18) Do you smoke cigarettes or consume tobacco (chewing paste) / alcohol, nicotine or marijuana in any form? ☐ Yes ☐ No
Please give duration and daily consumption _____

19) 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

20) Have you or any of your immediate family members (father, mother, brother or sister) have/ had cancer, heart attack, or stroke and at What age?
Prior to age 60yrs? ☐ Yes ☐ No

If yes please provide details

_____

_____

_____

21) Please confirm, if any of the person to be insured is pregnant (For Females Only)If yes, please state how many months?_____

☐ Yes ☐ No

22) Do you or any of the family members to be covered have/had any health complaints/met with any accident in thepast 4 years and have been taking treatment/ hospitalization? (Please provide details in the table given below)

☐ Yes ☐ No

23) Illness/injury details of the past 4years and prior to 4 years.

| Sr. No | Name of the person | Name of the Illness /injury suffered / suffering in the past 4 years | Treatment details | Date first treated | Name of the Illness / injury suffered any time in the past (prior to 4 years) | Treatment details | Date first treated | Current Status of the Illness/ Diseases/Injury |
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24) Has any proposal for life, critical illness or health related insurance on your life or lives ever been postponed, declined or accepted on special terms? If yes, give details_____

25) Family Doctor Details:

Name:

Qualification: Mobile

Address:

Reg No:

## Declaration

☐ "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.

☐ 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.

☐ 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.

☐ I/We declare and consent to the company seeking medical information from any doctor or from a hospital who at anytime 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.

☐ 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 Proposer

Name and Designation:_____

## 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 or continuing 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 FIVE HUNDRED RUPEES. Certified that the contents of the Proposal Form and documents have been fully explained to the Proposer and that he/they have fully understood the significance of the proposed contract***

Date :_____

Place :_____

Signature of Proposer

Name and Designation:_____

*** This is required only where, for any reason, the Proposal Form and other connected papers are not filled by the Prospect/Proposer.

** Please read declaration wordings carefully before signing the proposal form.

# PORTABILITY FORM

## PART I

1) Name of the Policyholder / insured (s)_____

2) Date of Birth / Age _____

3) Address of policyholder /insured _____

4) Details of existing insurer

i. Name of the product_____

ii. Sum Insured_____

iii. Cumulative Bonus_____

iv. Add ons/Riders taken_____

v. Policy Number_____

5) Details of the proposed insurance

i. Name of the product proposed/intended to take_____

ii. Sum insured proposed_____

iii. Whether Cumulative Bonus to be converted to an enhanced sum insured_____

6) Reason (s) of portability_____

7) No of family member to be included in the policy to be ported _____

| First Name of Insured | Details of Previous Health Insurance Policy / Policy No. | Health ID Card number | Sum Insured | CB | Period of Insurance | | First Policy inception date |
|---|---|---|---|---|---|---|---|
| | | | | | From dd/mm/yyyy | To dd/mm/yyyy | |
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Enclosure: Photocopy of the existing policy documents

Date D D M M Y Y Y Y

Signature of Proposer

## PART II

1. Whether the PED exclusions / time bound exclusion have longer exclusion period than existing policy (Please indicate Yes /No) ☐ Yes / ☐ No

2. If yes , please give written consent to the declaration below:

"I am aware that the waiting period for the following disease (s)/ treatment (s) is .....days/years more than the previous policy terms, I hereby agree to observe the additional waiting period for the following diseases (s)/ treatments (s)

Signature of Policyholder