# PROPOSAL FORM FOR FAMILY FLOATER 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) For persons above 45 years of age or persons below 45 years of age, having adverse medical history declared in the proposal form 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 of the check up to be done are available with the Divisional Office/Branch Office.

C) If other family members residing with proposer i.e. spouse, eligible dependent children and dependent parents and dependent parents in law 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.

D) 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.

E) **Non-disclosure of facts material to the assessment of the risk, providing misleading information, fraud or non-co-operation by the insured will nullify the cover under the policy.**

1. NAME OF PROPOSER : Mr/Mrs._____

2. RESIDENTIAL
   ADDRESS:_____

   Tel.No:_____Fax No. E-Mail:____

3. Occupation: (please Tick)
   - ❑ Professional/Administrative/Managerial
   - ❑ Business /Trader
   - ❑ Clerical, Supervisory and related worker
   - ❑ Hospitality and Support Worker
   - ❑ Production Worker, Skilled and non-Agricultural Labourer
   - ❑ Farmer and Agricultural Worker
   - ❑ Police/Para Military/Defence
   - ❑ Housewife
   - ❑ Retired Person
   - ❑ Student – School and College
   - ❑ Any Other

4. Average Monthly Income Rs._____ Income Tax PAN No:_____

5. NAME, ADDRESS & TEL.NO: OF FAMILY PHYSICIAN_____
_____
QUALIFICATION:_____ REGN .NO: _____

6. Are you a member of Recognized Health Club/Gymnasium:
If yes, then submit proof of your membership _____

7. Are you at present or have you been at any other time in the past covered under any other Insurance (PA, Cancer Insurance, Hospitalization Insurance or other Medical Insurance). If so, give particulars of:

| Sr. No. | Content | Details |
|---|---|---|
| | Name of Insurer | |
| | Insurance Scheme | |
| | Policy No. | |
| | Period of cover | |
| | Claim Amt. Recd./receivable | |

8.Any proposal for this Insurance or any other similar insurance refused or cancelled or higher premium charged. If so, give details:

**9.DETAILS OF PERSONS TO BE INSURED:**

| Sr. No: | Name of all the persons | Date of Birth | Sex (M/F) | **Relation (*)** with the Proposer | Sum Insured selected | History of (Pl s. Tick) | | Signature |
|---|---|---|---|---|---|---|---|---|
| | | | | | | Diabetes | Hypertension | |
| 1 | | | | | | | | |
| 2 | | | | | | | | |
| 3 | | | | | | | | |
| 4 | | | | | | | | |
| 5 | | | | | | | | |
| 6. | | | | | | | | |

**(*)Relation as per following table**

| Self | Spouse | Daughter |
|---|---|---|
| Son | | |

10. MEDICAL HISTORY: Please answer the following questions with Yes or No (A dash is not sufficient and give full details in respect of all the persons to be insured)

1) Are all the members proposed for insurance in good health and free from physical and Mental disease or infirmity? If no, give details of the illnesses/ diseases for each member. **Select the illness/conditions from the table given below:**

| Sr. No. | Name of the Person | Nature of illness/pre-existing diseases (*) |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

***Table for selecting Pre-Existing Disease (PED)**

| | | |
|---|---|---|
| Ischaemic Heart Disease | Hypertension | Diabetes Mellitus |
| Spinal or Vertebral Disorders | Cataract | Breathing Disorders |
| Uterine Bleeding | Arthritis and Joint disorders | Gastritis and Duodenitis |
| Kidney disorders | Headache Syndromes | Hernia |
| Stroke and T.I.A. | Thyroid and Other Hormonal Disorders | E.N.T. Disorders |
| Cholelithiasis | Any Malignancy | Hemorrhoids |
| Enlargement of Prostate (BPH, enlargement of prostate) | Any Other (Please specify) | |

2) Has any of the persons proposed for insurance has suffered from any illness/disease or had an accident in **the past**? If so, give details as under:

| Name of the person | Nature of illness/disease/injury & treatment received | Date on which first treatment taken | First treatment completed/is continuing | Name of attending medical practitioner/surgeon with his address & tel. Nos. |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

**Note**: This information should be given for any of the persons proposed for insurance, if he/she had suffered from any illness/disease injury, please give details separately.

3) Are there any additional facts affecting the proposed Insurance, which should be disclosed to insurers? If yes, then give details below:

4) Please give details of any knowledge or any positive existence or presence of any ailment, sickness or injury, which may require medical attention? If yes, then give details below:

5) Where do you wish to take treatment? : Zone I (Mumbai)
Zone II (Delhi/Bangalore)
Zone III (Rest of India)

6) Name of the Assignee- Relationship

7) Period of Insurance: From_____ To _____

**8) Declaration**: I declare that the persons proposed for insurance are my family members and they are not engaged in high risk occupation. I also declare that none of them suffer from any pre-existing conditions and that I have given explicit information of such sickness/disease/injury sustained in the above columns where the information has been sought. I further declare that the above statements in respect of myself and my family members, are true and complete. I consent and authorize the insurers to seek medical information from any Hospital/Medical Practitioner who has at any time attended me or my family members or may attend concerning any disease or illness which affects my or my family members, physical or mental health. I agree that this proposal shall form the basis of the contract should the insurance be affected. If after the insurance is affected, it is found that the statements, answers or particulars stated in the Proposal form and its Questionnaires are incorrect or untrue in any respect, the Insurance Company shall incur no liability under this insurance.

Photographs of Insured Persons:

| Proposer | 1 | 2 | 3 | 4 | 5 | 6 |
|---|---|---|---|---|---|---|

**Signature of the Proposer:_____Date: _____/_____/_____**
**DD MM YY**

**Place:_____**

**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 five hundred rupees.

**FOR OFFICE USE ONLY:**

| Sr. No. | Name of insured person | Date of Birth /Age | Sex M/F | Relation | Occupa-tion | S.I. (Rs.) | CB % | Premium | Loading for diabetes and hypertension | Loading for high claim ratio |
|---|---|---|---|---|---|---|---|---|---|---|
| 1 | | | | | | | | | | |
| 2 | | | | | | | | | | |
| 3 | | | | | | | | | | |
| 4 | | | | | | | | | | |
| 5 | | | | | | | | | | |
| 6 | | | | | | | | | | |
| **Remarks of Underwriter:** | | | | | **Total:** | | | | | |
| | | | | | **Loyalty Discount** | | | | | |
| | | | | | **Family Discount 10%** | | | | | |
| | | | | | **Service Tax** | | | | | |
| | | | | | **Gross Total** | | | | | |