Bajaj General Insurance Limited
(Formerly known as Bajaj Allianz General Insurance Co. Ltd.)
Bajaj Insurance House, Airport Road, Yerawada, Pune - 411006. IRDAI Reg No.: 113.
CIN: U66010PN2000PLC015329
Email: careforyou@bajajgeneral.com | Website: www.bajajgeneralinsurance.com
Sales - 1800 209 0144 / Service - 1800 209 5858 (Toll Free No.)

BAJAJ GENERAL
CARINGLY YOURS

HEALTH POLICY RENEWAL REVISION REQUEST FORM

Instructions for filing up the Proposal Form:

1. Please answer all questions in BLOCK letters and attach the renewal notice along with this form.
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.

Existing Policy:

☐ My Health Care Policy	☐ Health Ensure	☐ Silver Health	☐ Extra Care Plus
☐ Health Care Supreme	☐ Health Guard	☐ Aap Ke Liye	

Policy Number:

Proposer name:

Title:	
First Name:	
Middle Name:	
Surname:	

Request for change in:

☐ Sum Insured	☐ Address	☐ Member Addition	☐ Member Deletion
☐ Change in DOB (Please enclose age proof)	☐ Change in Gender	☐ Inclusion of Co-Payment Wavier (For Non-Network Hospitals)	

New address: Details to be filled if address has to be changed

House No.:			
House Name:			
Area/Road Name:			
Landmark/Locality:			
City:			
State:		Pin Code:	
Telephone No. (Res):		Mob No.:	
Email ID:			

Change in Sum Insured/Gender/DOB/New member addition/Member Deletion: Details to be given in the below table

Sr. No.	Name of the Insured	DOB (DD/MM /YYYY)	Age	Gender (M/F/ Other)	Relationship with Proposer	Occupation	Ht	Wt	Nature of Work	New Sum Insured	Adverse Health Condition/Illness/ Disease/Deformities

Please provide details in the below table if you have any adverse health condition /illness/Disease/deformity

Sr. No.	Name of the Insured	Please specify the illness details with symptoms	Treatment details with treating Doctor details	Outcome of treatment (e.g. Ongoing, complete recovery, recurrent or likely to recur)

Date: DD / MM / YYYY
Place:

Signature of the Proposer