

Sr. No.	Name of the Insured	ABHA Number (14 Digits)	Employee Code/ Account No (if Applicable)	Relationship of the dependent members to the Employee/ Member	DOB (DD-MM-YYYY)	Gender	Ht. (cms)	Wt. (kgs)	Sum Insured (Floater)	Pre- Existing Disease (if any)
5										
6										
7										
8										
9										
10										

ABHA Declaration (Applicable only if you have shared the ABHA number with Us)

I/We provide my/ our consent to access my/ our (all insured) medical and personal records/ details, as are available in my/ our Ayushman Bharat Health Account (ABHA) and share the same with Third Party Administrators, Reinsurer (if applicable), Service Provider/s of Bajaj General and/or with any Governmental and/or Regulatory authority for the sole purposes of underwriting my/ our proposal and/ or for checking the authenticity of claims lodged by me/ us and/ or to comply with the applicable Law/ Regulations

Nominee Details:	Name	DOB (dd/mm/yyyy)	Age	Relation
Nominee*				
Appointee (If nominee is minor)				
If Nominee is "Others" please specify the relationship and reason _____				
*Nominee for Self (Primary Insured/Proposer) has to be one of the mentioned relations - Father/ Mother / Son / Daughter / Spouse/Other				
*For all family member Primary insured will be the Nominee				

Please attach additional sheets, if space not sufficient to complete details.

10. Non-Medical Expenses Cover (Rider) YES NO

Note- This rider can be availed with Sum Insured options of INR 5,00,000 and above on payment of extra premium

11. Health Prime Ride(Group) Individual Floater Plan Option _____

12. Do you smoke cigarettes or consume tobacco (chewing paste) / alcohol, nicotine or marijuana in any form? Please give duration and daily consumption?

13. 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

14. 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. YES NO

15. Have you or any of the persons proposed to be insured were/are detected as Covid positive? YES NO

16. Do you or any of the family members to be covered have/had any health complaints/met with any accident in the past 4 years and prior to 4 years and have been taking treatment, regular medication (self/ prescribed)or planned for any treatment / surgery / hospitalization? (Please provide details in the table given below)

If the reply is YES for question 13 to 15 please share details in below table

YES NO

Member Name	Name of the Illness/injury suffered /suffering in the past	Treatment details	Date first treated	Current Status of the Illness/Diseases/Injury	Vaccinated against COVID-19? (Yes/No)

17. Have any of your immediate family members (father, mother, brother or sister) have/ had diabetes, hypertension, cancer, heart attack, or stroke and at what age? YES NO

If yes, was it before age 60 years or after 60 years?

Member Name	Relationship with Proposer	Disease Name	At what Age illness suffered
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18. Payment Details Cash Cheque DD Credit Card Debit Card

Cheque Given By Spouse Father Mother Son/Daughter Financer Employer/Employee

BIMA ASBA Declaration (Applicable only in case Premium payment through online payment mode)

under the BIMA ASBA facility and debit the same from my bank account upon acceptance of this proposal. In case the proposal is not accepted, I accord my consent to debit only the expenses incurred towards medical examination, if any, and unblock the balance amount

Amount	Transaction No.		Bank Name	Branch

Declaration*

- 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.
- 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.
- 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 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.
- I/We hereby authorize and give my/our consent to Company to collect my/our personal and medical information/data available in my/our Ayushman Bharat Health Account (ABHA). Further I/we hereby authorise Company to use/share the information/data, pertaining to my proposal and/or collected from my/our ABHA, with reinsurer, Service Provider and or with any Governmental and/or Regulatory authority, for the sole purpose of proposal underwriting and/or claims settlement and or to comply with applicable laws/regulations.

Date ____/____/____

Place : _____

Signature/ Thumb Impression of the Proposer

The content of this form and its particulars have been explained by me in vernacular language to the proposer who has understood and confirmed the same**

Date _____

Place _____

Signature of Proposer

Signature of Intermediary

Name of Witness: _____

Signature of Witness

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

Disability Declaration

Any Physical deformity or handicap? Yes/ No

If Yes. Please provide details: _____ (Disability Certificate issued by the Medical Board appointed by the Government for certifying Disability)

I _____ authorised representative of Mr./Miss/Mrs. _____ hereby giving consent on the behalf of the proposer due to his/her disability, that he/she has understood the content of this form and its particulars and confirmed the same.

Name of Authorised Representative: _____

Date: _____

Signature of Authorised Representative: _____

Place: _____

Agent details

Agent/IMD Name _____ Agent/IMD Code _____ Agent/IMD Signature _____

SP / BQP / DP / PoS Name _____ SP / BQP / DP / PoS CoR No.: _____

SP / BQP / DP / PoS Signature _____

Agent Declaration

I, [Full Name], acting in my capacity as an Insurance Advisor/Specified Person of the Corporate Agent/Authorized Employee of the Broker/Relationship Officer, hereby declare that I have explained all the contents of this Proposal Form, including the nature of the questions contained herein, to the Proposer in their vernacular language, if required. This includes all statements, information, and responses submitted by the Proposer in this Proposal Form to the questions contained herein or any details sought herein. These details will form the basis of the Contract of Insurance between the Company and the Proposer if this Proposal is accepted by the Company for the issuance of the Policy.

I have further clarified that if any untrue statement(s), information, or response(s) is/are contained in this Proposal Form, including any addendum(s), affidavits, statements, or submissions furnished or to be furnished, the Company shall have the right to vary the benefits payable. Moreover, if there has been a non-disclosure of any material fact, the policy issued to the Proposer pursuant to this Proposal may be treated by the Company as null and void, and all premiums paid under the Policy may be forfeited to the Company.

Date: _____

Place: _____

Signature of Agent: _____

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

Section 41 of Insurance Act 1938 as amended by Insurance Laws Amendment Act, 2015 (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 default in complying with the provisions of this section shall be punishable with fine which may extend to rupees ten lakh.

ACKNOWLEDGEMENT:

Received from Ms./Mrs./Mr: _____ through Cash# / Cheque / DD / Credit Card / Debit Card No. _____ against your proposal for Health Policy. sum of Rs. _____

Signature of Bajaj General Official/ Intermediary: _____ Date: _____ Time: _____ Place: _____

Bajaj General Official /Intermediary Name: _____

Note: Neither the submission of a completed proposal for insurance or any payment for any policy sought obliges the Company to agree to issue a policy, which decision is and always shall be in the Company's sole and absolute discretion

DECLARATIONS – PHYSICAL PROPOSAL FORM

- Are you or any of the proposal applicants a PEP* or a close relative of PEP*?

If yes, please share the details _____

“Politically Exposed Persons” (PEPs) are individuals who are or have been entrusted with prominent public functions in a foreign country, e.g., Heads of States/Governments, senior politicians, senior government/judicial/military officers, senior executives of state-owned corporations, important political party officials, etc.”

Yes / No

- I/we hereby give my/our consent to the Company to verify and obtain my/our identity/address proof through Central KYC Registry or Goods and Service Tax Portal or Ministry Of Corporate Affairs Portal or National Securities Depository Limited portal for the purpose of undertaking KYC. Yes / No

- I/we hereby agree and ensure to maintain details of all the beneficiaries covered under the policy and shall share the same with the Company as and when required. Yes / No

- I/We hereby give voluntary consent to Bajaj General/Company to share my/our personal information and data provided in this proposal form with any other person in connection with the Insurance Policy or otherwise, including for providing products and services of group companies that may be of interest to me/us, to be used in accordance with their respective privacy policies and subject to appropriate measures being in place to safeguard my/our personal information. Yes / No