

ABHA Declaration (Applicable only if you have shared the ABHA number with Us) <input type="checkbox"/> 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	
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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

5. Selection of Rider/Add on

Health Prime Rider	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Individual	<input type="checkbox"/> Floater
Plan Option _____				

6. Health Questioner

a. Do you smoke cigarettes or consume tobacco (chewing paste)/ alcohol, nicotine or marijuana in any form? If Yes Please give duration and daily consumption? _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
c. 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 _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
d. 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 tumour 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, ts (epilepsy) slipped disc, backache, any congenital/ birth defects/ urinary diseases, AIDS or positive HIV.	<input type="checkbox"/> Yes	<input type="checkbox"/> No
e. Have you or any of the persons proposed to be insured were/are detected as COVID positive?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
f. 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?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

If the reply is YES to any questions from a. to f. above, please share details in below table

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

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? If yes, was it before age 60 years or after 60 years? _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
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Member Name	Relationship with Proposer	Disease Name	At what Age illness suffered

7. Additional Details

Payment Mode	<input type="checkbox"/> Full Payment		<input type="checkbox"/> Instalment Payment			
	<input type="checkbox"/> Monthly	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Half	<input type="checkbox"/> Annual		
Payment Details	<input type="checkbox"/> Cash	<input type="checkbox"/> Cheque	<input type="checkbox"/> DD	<input type="checkbox"/> Credit Card	<input type="checkbox"/> Debit Card	<input type="checkbox"/> UPI
Cheque Given By	<input type="checkbox"/> Spouse	<input type="checkbox"/> Father	<input type="checkbox"/> Mother	<input type="checkbox"/> Son/Daught	<input type="checkbox"/> Financer	<input type="checkbox"/> Employer/E

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.	Transaction Date	Bank Name	Branch
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Electronic-Insurance Account
 Please provide e-IA No. to deposit your insurance policy. _____ Do you want to open e-IA account Yes No

Bank Details
 Name as per Bank Account _____

Name of the Bank:	IFSC Code:
Bank Account No:	Account Type:
Mobile No:	Email Address:

 aforesaid Bank Account and also agree to inform if there is any change in the above contact or bank details, for ensuring smooth policy servicing.

In case of any Offer, you would prefer to be contacted by:	<input type="checkbox"/> Phone	<input type="checkbox"/> Email	<input type="checkbox"/> WhatsApp
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8. 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 Intermediary _____ 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: _____

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.

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 default in complying with the provisions of this section shall be liable for a penalty which may extend to ten lakh rupees.



ACKNOWLEDGMENT:

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

Date: _____

P D M M Y Y Y Y

Signature of Bajaj General Official/ Intermediary

Bajaj General Official / Intermediary Name: _____ Time: _____ Place: _____

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.

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 _____

FirstName of Insured	Details of previous health insurance policy /Policy number	Health Id card number	Sum Insured	CB	Previous Insurance		First policy inception date
					From dd/mm/yy	To dd/mm/yy	

Enclosure: Photocopy of the existing policy documents

Date ____/____/____

Signature of Policyholder

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) isdays/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

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 CERSAI records or National Securities Depository Limited Portal for the purpose of undertaking KYC verification.
- I/we hereby declare and confirm that the premium has been paid out of legally acquired sources of income and the subsequent premiums if any, will continue to be paid out of legally declared and assessed source of income.
- I/We hereby give voluntary consent to Bajaj General/Company to share my/our personal information and data provided in this proposal form with its group companies or 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