Bajaj General Insurance Limited
(Formerly known as Bajaj Allianz General Insurance Co. Ltd.)
Regd. Office & Head Office: Bajaj Insurance House, Airport Road, Yerawada, Pune - 411006.
IRDAI Reg No.: 113 | CIN: U66010PN2000PLC015329
UIN: BAJHLIP26074V022526, Add-on /Rider cover: Insta Shield: BAJHLIA26072V012526 | Fetal Flourish: BAJHLIA26070V012526 | NRInsure: BAJHLIA26076V012526 | Health Prime (Rider): BAJHLIA24087V022324
SMART Riders- BAJHLIA27077V012627 For more details, log on to: www.bajajgeneralinsurance.com
Email: careforyou@bajajgeneral.com or Toll Free: 1800 209 0144 / Service - 1800 209 5858 (Toll Free No.)

BAJAJ GENERAL
CARINGLY YOURS

Proposal Form Unique Reference Number: Bajaj General/ Health/ Individual/015								
For Office Use Only			For Agent Use Only					
Scrutiny No.	Receipt No.	Policy No	Loan Account Number	Emp/LG Code	IMD Code	Sub IMD Code	IMD Name	Mobile No

PROPOSAL FORM

MY HEALTH CARE PLAN EDGE+

Instructions for filing up the Proposal 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 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.

1. Proposer Details

1) Full Name: Title; First Name:
Middle Name: Surname:

2) Are you an existing Bajaj General Customer: ☐ Yes ☐ No
if yes please share below details,
a. The Policy No.: _____
b. Existing Customer (PID) No.: _____
☐ I hereby confirm that; there is no change in my existing KYC details that are available from my previous/existing policy.

3) Gender: ☐ Male ☐ Female ☐ Other 4) Date of Birth:
5) Pan No.: 6) Aadhar ID:
7) Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed
8) No. of Children: __Sons __Daughters 9) Bajaj Employee Code if Proposer is General/Life Employee
10) Occupation: ☐ Business ☐ Salaried ☐ Professional ☐ Student ☐ Housewife ☐ Retired ☐ Others_____
11) Are you or any of your family members registered under the Ayushmaan Bharat Yojana? ☐ Yes ☐ No
If yes, please share your Ayushmaan Bharat Health Account Number (ABHA) in below table 'Details Of Persons to Be Insured'

2. Address Details
a) Permanent /Residential Address

House No.:
House Name:
Landmark/Locality:
Road/Area Name: City:
State: Pin Code:
Telephone (Res.): Telephone (Office):
Mobile Number: E-mail: _____

b) Communication Address (all communications will be sent to below)

House No.:
House Name:
Landmark/Locality:
Road/Area Name: City:
State: Pin Code:
Telephone (Res.): Telephone (Office):
Mobile Number: E-mail: _____

3. Other Details

i) Educational Qualification: ☐ Matriculate ☐ Undergraduate ☐ Graduate ☐ Postgraduate ☐ Professionally Qualified

ii) Proposer Monthly Income: INR _____

iii) Nationality: _____

iv) Policy Term: ☐ 1 Year ☐ 2 Years ☐ 3 Years ☐ 4 Years ☐ 5 Years

v) Proposed Period of insurance: From: _____/_____/_____ To: _____/_____/_____

vi) Policy type: ☐ Individual ☐ Floater

4. Details Of Persons to Be Insured

Sr No	Member Name	Relationship with Proposer	DOB (dd/mm/yyyy)	Age	Gender (M/F)	Ht. (CMS)	Wt. (kgs)	ABHA Number
1)								
2)								
3)								
4)								
5)								
6)								
7)								

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	Percentage of Nomination
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. Sum Insured Details		
Member Name	Sum Insured (Individual)	Sum Insured (Floater)

6. Optional Covers/Riders:

1) Variation in Room Rent* (Default Single Private A/C Room)	☐ Yes ☐ No	13) Consumables Plus (For SI above 10 Lakhs)	☐ Yes ☐ No
2) Reduction in Pre-Existing Disease Waiting Period* (Default 36 months)	☐ Yes ☐ No	14) Smart Tenure	☐ Yes ☐ No
3) Reduction in Specific Disease Waiting Period* (Default 24 months)	☐ Yes ☐ No	15) Health Limitless (For SI 10 lakhs and above)	☐ Yes ☐ No
4) Air Ambulance*	☐ Yes ☐ No	16) Walk to win Discount	☐ Yes ☐ No
5) Major Illness and Accident Multiplier (Indemnity)	☐ Yes ☐ No	17) Global Cover (For SI above 10 Lakhs)*	☐ Yes ☐ No
6) Double Sum Insured Benefit	☐ Yes ☐ No	18) Age Shield	☐ Yes ☐ No
7) Cost of Prescribed External Medical Aid	☐ Yes ☐ No	19) Health Prime Rider*	☐ Yes ☐ No
8) Super Cumulative Bonus*	☐ Yes ☐ No	20) Fetal Flourish*	☐ Yes ☐ No
9) Consumables Expenses (For SI 5 Lakh, 7.5 Lakh, 10 Lakh)	☐ Yes ☐ No	21) NRInsure*	☐ Yes ☐ No
10) Voluntary co-payment*	☐ Yes ☐ No	22) Insta Shield*	☐ Yes ☐ No
11) Voluntary Aggregate Deductible*	☐ Yes ☐ No	23) International Cover- Emergency Care Only	☐ Yes ☐ No

***If any of the above optional covers/ riders are opted please select the relevant option from below table-**

Variation in Room Rent: ☐ Twin Sharing ☐ Actuals	**Reduction in Specific Disease Waiting Period:** ☐ 12 months
Reduction in Pre-Existing Disease Waiting Period: ☐ 12 months ☐ 24 months	**Voluntary Co-Payment:** ☐ 5% ☐ 10% ☐ 15% ☐ 20% **Or** **Voluntary Aggregate Deductible** ☐ 50K ☐ 1 Lakh ☐ 2Lakh
Super Cumulative Bonus: ☐ 50% upto 200% ☐ 50% upto 500% ☐ 100% upto 200% ☐ 100% upto 500% ☐ 100% upto 600%	**Global Cover: Mandatory Co-pay Option** ☐ 10% ☐ 20% ☐ 30% ☐ 40% ☐ 50%
Air Ambulance If yes (specify amount in multiples of 1,00,000 max up to INR 10,00,000) _____	**Health Prime Rider:** If Yes, ☐ Individual ☐ Floater Plan Option_____

Cover Name	Primary Insured 1	Insured 2	Insured 3	Insured 4	Insured 5	Insured 6
Insta Shield	If yes, please select the conditions below ☐ Asthma ☐ Diabetes ☐ Hypertension (Blood pressure) ☐ Hyperlipidaemia (Cholesterol) ☐ Obesity ☐Hypothyroidism	If yes, please select the conditions below ☐ Asthma ☐ Diabetes ☐ Hypertension (Blood pressure) ☐ Hyperlipidaemia (Cholesterol) ☐ Obesity ☐Hypothyroidism	If yes, please select the conditions below ☐ Asthma ☐ Diabetes ☐ Hypertension (Blood pressure) ☐ Hyperlipidaemia (Cholesterol) ☐ Obesity ☐Hypothyroidism	If yes, please select the conditions below ☐ Asthma ☐ Diabetes ☐ Hypertension (Blood pressure) ☐ Hyperlipidaemia (Cholesterol) ☐ Obesity ☐Hypothyroidism	If yes, please select the conditions below ☐ Asthma ☐ Diabetes ☐ Hypertension (Blood pressure) ☐ Hyperlipidaemia (Cholesterol) ☐ Obesity ☐Hypothyroidism	If yes, please select the conditions below ☐ Asthma ☐ Diabetes ☐ Hypertension (Blood pressure) ☐ Hyperlipidaemia (Cholesterol) ☐ Obesity ☐Hypothyroidism
NRInsure	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Fetal Flourish	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

Health Questionnaire (If Fetal Flourish Rider is opted):

1. Have you or your spouse / partner or family member of either family (maternal or paternal) suffered from or are suffering from any genetic disease or have been advised any test to evaluate genetic disorders? Examples- Thalassemia, Down Syndrome, Sickle Cell Anaemia, Cystic Fibrosis, Haemophilia or any other chromosomal abnormality, etc. ☐ Yes / ☐ No
   If YES to question 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/ Disease/ Injury

Important Points:

1. **NRInsure:** By selecting 'Yes,' you hereby acknowledge and confirm that insured's residency status is NRI/OCI.
   The following documents must be submitted for verification at the time of inception and all subsequent renewals:
   - A copy of valid Passport with applicable Visa Stamping.
   - Applicable Tax Documentation, Work Visa, or Employment/Work Permit outside of India.
   - A signed Residential Agreement (lease/rental or ownership) in the overseas address.
   - Any other document as may be specified by the Company from time to time.
2. Optional Covers / Riders selected by proposer will be applicable to all dependent members.

7. Fitness Discount: (Please share the details of the marathon run in the table below)

Member Name	Name of Marathon	Date (within 12 months)	No. of Kilometer run
Member 1			
Member 2			
Member 3			
Member 4			
Member 5			
Member 6			

8. Loyalty Discount: Do you have a Bajaj General Motor, Health, Home, Cyber and Pet Insurance policy with a premium more than INR 2500.

☐ Yes / ☐ No

If yes please provide the details in below table.

Member Name	Policy number	Policy period	LOB
Member 1			
Member 2			
Member 3			
Member 4			

Member 5			
Member 6			

9. Health Status

a. 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
If yes, indicate in the table given below. If yes please provide details,

b. 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? ☐ Yes / ☐ No

c. Do you smoke cigarettes or consume tobacco (chewing paste) / alcohol, nicotine or marijuana in any form?
☐ Yes / ☐ No
Please give duration and daily consumption_____
If the reply is YES to any questions from a. to c., please share details in below table,

Member Name	Name of the Illness /injury suffered / suffering in the past	Treatment details	Date first treated	Current Status of the Illness / Diseases / Injury

d. 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

e. 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? ☐ Yes / ☐ No
If yes, give details, _____

f. Have you or any of the persons proposed to be insured were/are detected as Covid positive. ☐ Yes / ☐ No
If Yes, Give Date of Detection and Treatment Details_____

10. Additional Details

Payment Mode: ☐ Full Payment

☐ Instalment Payment: ☐ Monthly ☐ Quarterly ☐ Half Yearly ☐ Annual

Payment Details: ☐ Cash ☐ Cheque ☐ DD ☐ Credit Card ☐ Debit Card ☐ UPI

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

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

☐ I hereby accord my consent to authorise Bajaj General Insurance Limited to block the applicable premium payable for the aforesaid insurance policy 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 Name: _____

11. Electronic-Insurance Account

Please provide e-IA No. to deposit your insurance policy.: _____
Do you want to open e-IA account: ☐ Yes / ☐ No

12. Bank Details

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

☐ I/We hereby authorize Bajaj General Insurance Limited ("the Company") to refund any amount related to my policy and/or claim directly credited to my aforesaid Bank Account and 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: ☐ Phone ☐ Email ☐ WhatsApp

13. 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 Individual Policy/floater Policy, and the proposal is subject to the Board approved underwriting policy of the Company and that the Policy will come into force only after Company's full receipt and realization 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 Insured Person(s) to be insured/ proposer after the proposal has been submitted but before communication of the risk acceptance by the Company. Upon renewal of Policy, I/We agree to abide by the standard Terms and Conditions, unless otherwise mentioned by the Company in renewal Policy Schedule or attachments thereto.
- I/ We declare and consent to the company seeking medical information from any doctor or from a hospital/institution who at any time has attended on the Proposer/Insured Person to be insured 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 reinsurer, Governmental and/or Regulatory authority.
- 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.

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 the Proposer

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/Propose 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: ____/____/_____

Place: _____

_____
Signature of Authorised Representative

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, _____

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.

14. DECLARATIONS – PHYSICAL PROPOSAL FORM

- Are you or any of the proposal applicants a PEP* or a close relative of PEP*? ☐ Yes / ☐ No

  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/juridical/military officers, senior executives of state-owned corporations, important political party officials, etc."

- 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

It is mandatory to keep your policy with updated contact (Mobile No., Email ID and PAN Card) and bank account details, to process any of your service requests faster and hassle-free in future.

You can update the same through

Bajaj General App: http://onelink.to/v9zp7c,

WhatsApp Service (Say 'Hi' on WhatsApp- +91 75072 45858),

Contact our 24-Hour Call Center at 1800-209-5858, 1800-102-5858, Give a Missed Call on 8080945060, SMS "WORRY" to 575758,

Email- careforyou@bajajgeneral.com

website- https://www.bajajgeneralinsurance.com/general-insurance.html

contact your agent or nearest branch.

GO GREEN

To support our Go Green initiative, we will send policy copy link on your registered mobile number/ email id. This is a digitally signed valid document. Please tick the box, if you still want to receive physical copy of your insurance policy. ☐

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: _____

Time: _____

Place: _____

_____
Signature of Bajaj General Official/Intermediary

Bajaj General Official/Intermediary Name: _____

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

*For Portability Proposal kindly fill the Portability Annexure separately.