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
MY HEALTH CARE-PLAN 6: UIN: BAJHLIP26074V022526 | Insta Shield: BAJHLIA26072V012526 |
Fetal Flourish: BAJHLIA26070V012526| NRInsure: BAJHLIA26076V012526
Web: www.bajajgeneralinsurance.com| Toll Free: 1800 209 5858 / 1800 209 0144
Email ID: careforyou@bajajgeneral.com

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 6

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.: OG_____

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 D D M M Y Y Y Y

5) Pan No. ☐☐☐☐☐☐☐☐☐☐

6) Aadhaar No. *Enter last 4 digits only* ☐☐☐☐

7) Bajaj Employee Code, if Proposer is General/Life Employee ☐☐☐☐☐☐

8) Marital Status ☐ Married ☐ Single ☐ Divorced ☐ Widowed

9) No. of children: ___Sons/ ___ Daughters

10) Occupation ☐ Business ☐ Salaried ☐ Professional ☐ Student ☐ House wife ☐ Retired ☐ Other _____

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

2. a. Permanent /Residential Address	2.b. Communication Address (all communications will be sent to below)
House No.: _____ House Name : _____	House No.: _____ House Name : _____
Landmark/Locality: _____	Landmark/Locality: _____
Road/Area Name: _____	Road/Area Name: _____
City/District: _____	City/District: _____
State: _____	State: _____
Pin Code: ☐☐☐☐☐☐	Pin Code: ☐☐☐☐☐☐
Telephone: _____ Mobile: _____	Telephone: _____ Mobile: _____
Email: _____	Email: _____

3. Other Details

i. Educational Qualification	☐ Matriculate	☐ Under Graduate	☐ Graduate	☐ Post Graduate	☐ Professionally Qualified

ii. Proposer Monthly Income: Rs. _____ Only

iii. Nationality: _____

iv. Policy Term:	☐ 1 Year	☐ 2 Years	☐ 3 Years	v. Proposed Period of Insurance	From	D	D	M	M	Y	Y	Y	Y
vi. Policy type		☐ Individual	☐ Floater		To	D	D	M	M	Y	Y	Y	Y

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vii. Sub- Plan	☐ Plan 1	☐ Plan 2	☐ Plan 3									
viii. Voluntary Co pay Discount	☐ 5%	☐ 10%	☐ 15%	☐ 20%								

Note: If opted voluntarily by the Insured then Insured will be eligible of additional 5%,10%,15% or 20% discount respectively on the policy premium. In case of a claim has been admitted under In-patient Hospitalization Treatment then, the insured person shall bear 5%,10%,15% or 20% respectively of the eligible claim amount payable under this cover

4. Details Of Persons To Be Insured

Name	Relationship with Proposer	DOB (dd/mm/yyyy)	Age	Gender (M/F)	Ht (cms)	Wt (kgs)	ABHA Number

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*

5. Plan and Sum Insured Details

Member Name	Sum Insured (Individual)	Sum Insured (Floater)

i. Sum Insured Options	☐ 3 Lacs	☐ 4 Lacs	☐ 5 Lacs	☐ 10 Lacs	☐ 20 Lacs	☐ 25 Lacs	☐ 50 Lacs	☐ 1 CR
ii. Waiting period (pre-existing disease)	☐ 12 months		☐ 24 months		☐ Default			

Note: The Base Plan will have 36 months by Default, Option selected by proposer will be applicable to all dependent members

iii. Waiting period (specific disease)	☐ 12 months	☐ 36 months	☐ Default

Note: The Base Plan will have 24 months by Default, Option selected by proposer will be applicable to all dependent

iv. Major Illness and Accident Multiplier ☐ Opted ☐ Not opted (Note : Optional cover opted by proposer will be applicable to all members)

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

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

Do you have Motor, Health, Home, Cyber and Pet Insurance with a premium more than INR 2500
If yes please provide the details in below table

	Policy number	Policy period	LOB
Member 1			
Member 2			

Member 3			
Member 4			
Member 5			

Rider Details

i. Insta Shield

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

ii. Fetal Flourish

Cover Name	Primary Insured 1	Insured 2	Insured 3	Insured 4	Insured 5
Fetal Flourish	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

Health Questionnaire

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 Anemia, Cystic Fibrosis, Hemophilia 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

iii. NRInsure

Cover Name	Primary Insured 1	Insured 2	Insured 3	Insured 4	Insured 5
NRInsure	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

Note:

1. By selecting 'Yes,' you hereby acknowledge and confirm that insured's residency status is NRI/OCI.

2. 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.

6. Health Questionnaire		
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? ____	☐ Yes	☐ No
b. 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 ____	☐ Yes	☐ No
c. 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	☐ Yes	☐ No

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.		
d. Have you or any of the persons proposed to be insured were/are detected as COVID positive?	☐ Yes	☐ No
e. 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
If the reply is YES to any questions from a. to e. 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?	☐ Yes	☐ No

Member Name	Relationship with Proposer	Disease Name	At what Age illness suffered

7. Additional Details

Payment Mode	☐ Full Payment	☐ Installment 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

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:	

☐ *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 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:	☐ *Phone*	☐ *Email*	☐ *WhatsApp*

8. 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 anytime 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.

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/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:

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: dd/mm/yyyy
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.

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GoGreen

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:

D	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 oblige 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 _____

First Name 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/yyyy	To dd/mm/yyyy	

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) is ……..days/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/juridical /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 ☐

It is mandatory to keep your policy with updated contact (Mobile No., Email and PAN Card) and bank account details, to process any of your service request 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- +917507245858}, 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 – http://www.bajajgeneralinsurance.com/general-insurance.html, contact your agent or nearest branch.