

**Bajaj Allianz General Insurance Co. Ltd**G.E. Plaza, Airport Road, Yerawada, Pune - 411006.
IRDA Reg No.: 113 | CIN: U66010PN2000PLC015329 | UIN: IRDA/NL-HLT/BAGI/P-H(C)/V.I/281/13-14

For Office Use Onl	y:		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.						

## **CRITICAL ILLNESS - PROPOSAL FORM**

## Instructions For Filling Up The Form:-

- 1. Please answer all questions in BLOCK letters
- $2. \ \ \, \text{The Liability of the Company does not commence until this Proposal has been accepted by the Company and premium has been paid}$

you provide	us with any a																															
Proposer Do																		NI.														
1) Full Name:	Title			_	Ļ					ı		ı				ŀ	irst	Nam	е									Ш	_	Ļ		_
	Middle I	Name			$\perp$											S	urna	ame											L	$\perp$		
ls your nar	ne mentio	ned a	bove	e as p	er y	our A	Aadh	aar C	Card?	? : □	YES		) If I	No, Pl	eas	e me	entio	n the	e Na	me a	as pe	er Aa	dhaa	ar Ca	rd							
2) Are you an	existing B	ajaj A	llian	z Cus	tom	er: Ye	es /	No	If ye	s, ple	ase	men	tion	the P	olic	y No	: 00															
3) Gender: N	Male 🗌	Fema	le [		Oth	er [										4) I	Date	of B	irth	:	D	D	M	M	Y		Y )	Υ	1			
5) PAN No.	PAN No.         6) UID/Aadhaar no.:																															
∟ 7) Bajaj Allianz	Employee	Code	e, if P	ropo	ser is	s BA0	SIC/E	BALI	C Em	ploy	ee:																					
8) Marital Stat	tus:	Marri	ied		Single	e [	Div	orce/	d		Wic	dowe	ed .			9) I	No. d	of Ch	ildre	en		Son	s				Dau	ıghte	ers			]
10) Occupatio		Busin				aried	_			onal		Stuc	dent		Но	use '	Wife	. [		Retir	ed		] 0	thers	 ;							
11a) Permane	nt / Resido	ential	Add	ress	:																											
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State		j						ĺ													ĺ			P	n Coo	de				Ī		ĺ
11b) Correspo	ndence A	ddres	s : (A	II the	con	nmui	nicat	ions	will	be se	nt to	o the	bel	ow ac	ddre	ess)																_
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Mobile Numb	er	İ	İ	İ	ĺ						E-I	Mail												(	<u> </u>							
12) Education	al Qualific	ation:		Matr	icula	ate		Und	er Gı	adua	ate		Grad	luate		Pos	st Gr	adua	ite	P	rofe	ssio	nally	Qua	lified							
13) Family Mo	nthly Inco	me:		Up to	o Rs.	20,0	000		Rs.	20,0	001 t	o Rs.	. 50,	000		F	Rs. 5	0,00	1 to	Rs. 1	L lak	h		Abo	ve Rs	. 1	akh			1		
14) In case of	any Offer,	you w	vould	l pre	fer to	o be	cont	acteo	d by:		Pho	ne		Ema	il	15)	) Nat	iona	lity										L	<u> </u>		
Details of the	ne persor	is to	be ir	sure	ed																											
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Section-II I	nsurance	Info	rma	tion																												
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If yes Policy N															_													г	_			
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Has any propo																					_	16	uı	L		J L			L.	<u> </u>	L.	<u> </u>
Insurance on y																												[		Yes		No
If ves, give det																																

PLE	ASE ANSWER ALL QUESTIONS BY CHECKING EITHER THE YES OR NO BOX	
1.	Are you now in good health and entirely free from any mental or physical impairments or deformities?	☐ Yes ☐ No
2.	Height(Cm.) Weight(Kg.) How much weight have you lost or gained over the last 12 months?(Kg.)	
	Reason for weight change:	
3.	Have you ever suffered or do you now suffer from:	
	a) Diseases of the circulatory system	
	(e.g. heart trouble, chest pain, rheumatic fever, high blood pressure, diseases of the arteries and veins)?	☐ Yes ☐ No
	b) Diseases of the respiratory system (e.g. tuberculosis, asthma, persistent cough, pneumonia or emphysema)?	☐ Yes ☐ No
	c) Diseases of the genito-urinary system (e.g. infections of the kidneys, urinary or genital organs, renal stones, venereal disease)?	☐ Yes ☐ No
	d) Diseases of the gastrointestinal system (e.g. digestive disorders, gastric or duodenal ulcer, hepatitis B, hepatitis Cor	□ V □ N-
	other disorders of the liver, disorders of the gall bladder)?	☐ Yes ☐ No
	e) Diseases of the nervous system or mental disorders (e.g. stroke, epilepsy, fits or fainting attacks, frequent headaches,	□ Vas □ Na
	nervous breakdown, depression or other mental or psychiatric disorder)?  f) Diabetes mellitus, cancer or tumour of any kind, or any diseases of the blood, glands, spleen, ears, eyes or skin?	☐ Yes ☐ No
		☐ Yes ☐ No
	g) Unexplained night-sweats and/or loss of weight, persistent fever, chronic or recurrent diarrhea, unexplained infections or swollen glands?	□ Voc □ No
	h) Any other diseases or ailments not mentioned above?	☐ Yes ☐ No
4.	Have you or any of your immediate family members (father, mother, brother, or sister) have/had cancer, heart attack, or	
4.	stroke and at what age? Prior to age 60?	□ Yes □ No
5.	Have you ever had or been advised to have hospital treatment or surgery?	☐ Yes ☐ No
	Have you ever had or been advised to have a blood test for AIDS or an AIDS-related condition or have you ever been refused	□ 163 □ 140
0.	as a blood donor?	□ Yes □ No
7.	In the past 5 years, have you consulted a physician for any reason or have you had any investigation such as blood or urine tests,	□ 163 □ 140
۲.	X-rays, electrocardiograms, ultra sonograms, CT scans or biopsy, other than for routine employment or immigration purposes?	□ Yes □ No
0	Have you ever received or do you now receive any personal accident, disability benefit, or disability-related payments?	☐ Yes ☐ No
	Are you at present or any time in past were on any medication, special diet, or treatment?	☐ Yes ☐ No
	Have you ever taken narcotics or other habit forming drugs or been treated or advised in connection with your alcohol consumption	□ 163 □ 140
10.	or the taking of drugs?	☐ Yes ☐ No
11	Do you participate or do you intend to participate in any hazardous sports or activities such as motor sports, climbing, parachuting,	□ 163 □ 140
11.	hang-qliding, or aviation except as a fare-paying passenger?	☐ Yes ☐ No
12	Are you pregnant (for female only)? If yes, please state how many months. Please state if you had any pregnancy related	□ 163 □ 140
12.	complication during your previous pregnancy/delivery?	☐ Yes ☐ No
13	Have you smoked or used any substance or product containing tobacco, nicotine or marijuana?	☐ Yes ☐ No
15.	If yes, please state duration and average daily consumption and type:	L 163 L 110
14	Name and address of your regular medical consultant:	
	sicians) on the reverse of this form and include your signature and the date.	
	Declaration*	
	<ol> <li>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 b complete in all respects to the best of my knowledge and that I am authorised to propose on behalf of these other persons.</li> <li>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 policy will come into force only after full payment of the premium chargeable.</li> <li>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 propose but before communication of the risk acceptance by the company.</li> <li>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 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 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</li> <li>I authorize the company to share information pertaining to my proposal including the medical records of the insured/proposer for the sole purpose of proposal and/or claims settlement and with any Governmental and/or Regulatory authority.</li> </ol>	ne insurer and that the all has been submitted to be insured/proposer information from any d/or claim settlement.
	Date/	
	Place : Signature/ Thumb Imp	ression of the Proposer
	Certified that the contents of the Proposal Form and documents have been fully explained to the Proposer and that he/they have fully understood the significance	en of the proposed
	contract**	e or the proposed
	Date//	
	Place:	ehalf of Proposer)
	*Please read declaration wordings carefully before signing the proposal form.  **This is required only where, for any reason, the Proposal Form and other connected papers are not filled by the Prospect/Proposer.	nan oi Froposer)
	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 kir 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 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 comply of this section shall be punishable with fine which may extend to rupees ten lakh.	renewing a policy

Section-III Health Status

0	ACKNOWLEDGEMENT:	
	Received from Ms. / Mrs. / Mr:	
	sum of Rs.	through Cash# / Cheque / DD / Credit Card / Debit Card No.

\_against your proposal for Health Policy. e:\_\_\_\_\_\_Place:\_\_\_\_\_