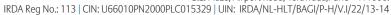


G.E. Plaza, Airport Road, Yerawada, Pune - 411006.





Relationship Beyond Insurance

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.	

HEALTH CARE SUPREME FAMILY FLOATER POLICY - PROPOSAL FORM

INSTRUCTIONS FOR FILLING UP THE FORM

Critical Illness:-

Personal Accident:-

Yes

No

- 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 we issue to you. It is therefore essential that you provide all the information in this Proposal FULLY AND ACCURATELY and that you provide us with any and all additional information relevant to risk to be insured or our decision as to acceptance of the risk or the terms upon which it should be accepted

upon which it should be accepted						
PROPOSER DETAILS						
1) Full Name Title						
Middle Name						
Is your name mentioned above as per your Aadhaar Card? : ☐ YES ☐ NO If No, Please mention the Name as per Aadhaar Card						
2) Are you an existing Bajaj Allianz Customer: Yes / No If yes, please mention the Policy No: OG						
3) Gender: Male Female 4) Date of Birth D D M M Y Y Y Y 5) PAN No.						
6) UID/Aadhaar no. 7) Bajaj Allianz Employee Code, if Proposer is BAGIC/BALIC Employee						
8) Marital Status Married Single Divorced Widowed 9) No. of Children Sons: Daughters:						
10) Occupation Business Salaried Professional Student House Wife Retired Others						
11 A) PERMANENT / RESIDENTIAL ADDRESS 11 B) CORRESPONDENCE ADDRESS: (All the communications will be sent to the below address						
House No. House House No. House						
Landmark/						
Locality						
Area Name Area Name City/District City/District City/District						
State						
Tel.						
Mobile						
Email						
E-Mail						
12) Educational Qualification: Matriculate Under Graduate Graduate Post Graduate Professionally Qualified						
13) Family Monthly Income: Up to ₹20,000 ₹20,000 ₹20,000 ₹20,001 to ₹50,001 to ₹50,001 to ₹1 lakh						
14) In case of any Offer, you would prefer to be contacted by: Phone Email 15) Nationality						
Medical Expenses Section :- Details of the persons to be insured						
DOB Ago Gender Us Was Occupation Relationsh						
Name Name Age (dd/mm/yy) Age (M/F) Ht Wt Occupation Relation Nominee of Nominee						
16) Period of Insurance: From D D M M Y Y Y To D D M M Y Y Y Y						
Add On Covers – Optional (please tick option opted for and mention sum insured in table given below)						
a. Ancillary Expenses Benefit Section:- Yes No No						

Sı	ım Insured Table:									
Sr No	o. Name	Hospita	lisation Section	Ancillary Expen	ises	Critical Illr	ness	Persona	al Accider	nt*
*	or dependent family members the ma	avimum Cum Incur	and under Dersonal	Assidant would be 7 E	lace					
17) [Oo you have any other Health policy/p or portability, please fill the portability	olicies, Personal Ac				if yes, please prov	vide the detai	ils in the below tab	ole. If opti	ing
	1 311 1			Details of p	revious	s	Perio	d of insurance	Eirct	nolicy
Na	ame of Insured	Name of Insurance Company		health ins policy / pol		Sum Insured	From MM/DD/Y	To Y MM/DD/YY	First policy inception date	
					policy / policies no		ז /טט/וווווו	ז ז ועוטוועון ז ז		
18) M	ledical history:-					1			1	
		Questions							Ye	es / No
	ng the last 4yrs and before 4yrs, have		ed insured consulte	ed any physician for tre	eatment or	medical investiga	ation or surg	ical operation,		
Have	dent or been hospitalized for any diso any of the proposed insured's ever be	een diagnosed wit		k treatment for any or	e or more	from the followin	ng: heart dise	ease, Diabetes/ rais	sed	
blood sugar, High blood pressure/ Hypertension, Circulatory disease? Paralysis, cancer, Disease of kidney, Liver, Stomach, Intestine, brain, Lung or joint disorder, mental illness, Congenital/ Birth defect, Physical deformity, or HIV/AIDS						DS				
			thyroid, Blood disorder or disorder of reproductive or urinary system						55	
Any other illness, impairment, disability or surgery not me										
	any of the proposed insured's Parent					or mental disord	er, hereditar	y or chronic disord	der?	
	y of the proposed insured currently ta y of the proposed insured currently p		on/ treatment for a	any disease or disorder	r?					
Have	any of the proposed insured proposa	al or application for	r reinstatement of	ife, health and accider	nt insuranc	e ever been decli	ned, postpor	ned, withdrawn or		
	oted with modified terms by any insu									
19) A	dditional information:- If you have ans	wered yes in any o			ils:-			Outcomo of	troatmou	nt
Sr No Name of the proposed insured			Please specify the illness details with symptoms			ent details with to Doctor details	e.g. Ongoing, cor	Outcome of treatment g. Ongoing, complete recovery recurrent or likely to recur)		
20) D	oes any person proposed to be insured	d smoke or consun	ne tobacco, alcohol	or any other form of T	obacco?	Yes No				
D	eclaration*									
1							or particulars	s given by me are	true and	
2		provided by me will	form the basis of th	e insurance policy, is sul			nderwriting po	olicy of the insurer	and that t	the
3	policy will come into force only after I further declare that I will notify in w				of the life	to be insured/pror	noser after th	e proposal has bee	n suhmitt	ted
	but before communication of the ris	sk acceptance by the	company.	-						
4	or from any past or present employe	er concerning anyth	ing which affects the	physical or mental healtl	h of the pers	son to be insured/	proposer and	seeking informatio	n from an	ny
5	insurer to whom an application fo	r insurance on the p	erson to be insured	/proposer has been ma	de for the I	purpose of underv	vriting the pro	oposal and/or claim	settlement	t.
3	proposal and/or claims settlement				corus or tilt	. msureu/proposer	ioi uie soie p	arpose or underwill	ing lile	
П	vate//									
						L	Signature/ Th	numb Impression of	the Propos	er
	lace :									
	ertified that the contents of the Proposal ontract**	Form and document	s have been fully exp	olained to the Proposer a	and that he/	they have fully und	derstood the s	ignificance of the pr	roposed	
D	ate//									

Place: _____*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.

Signature (On behalf of Proposer)

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.



To support our Go Green initiative, we will send the policy copy on your email. This is a digitally signed valid document. Please confirm if you still want to receive the physical hard copy of insurance policy ☐ Yes ☐ No

_	ACKNOWLEDGEMENT:
	Received from Ms. / Mrs



Mrs. / Mr: _through Cash# / Cheque / DD / Credit Card / Debit Card No. _against your proposal for Health Policy. Signature of Bajaj Allianz Official/ Intermediary: Place: Date: Time: Bajaj Allianz 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