

18) Do you smoke cigarettes or consume tobacco (chewing paste) / alcohol, nicotine or marijuana in any form? Please give duration and daily consumption? _____

19) 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 _____

20) 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

21) Have you or any of the persons proposed to be insured were/are detected as Covid positive? Yes No

22) 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? (Please provide details in the table given below) Yes No

If the reply is YES for question 20 to 22, 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	Vaccinated against COVID-19? (Yes/No)

23) 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?

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

24) Payment Details: Cash Cheque DD Credit Card Debit Card

Amount	Transaction No.	Transaction Date	Bank Name	Branch

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

****Certified that the contents of the Proposal Form and documents have been fully explained to the Proposer in the language known to him and that he/they have fully understood the significance of the proposed contract****

Date ____/ ____/ ____

Place: _____

Signature (On behalf 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 or if the Prospect/Propose is not knowing English.

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.

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.

ACKNOWLEDGEMENT:

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

Signature of Bajaj Allianz Official/ Intermediary: _____ Date: _____ Time: _____ Place: _____

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

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 No.	Health ID Card number	Sum Insured	CB	Period of Insurance		First Policy inception date
					From dd/mm/yyyy	To dd/mm/yyyy	

Enclosure: Photocopy of the existing policy documents

Date

D	D	M	M	Y	Y	Y	Y
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Signature of Proposer

PART II

1. Whether the PED exclusions / time bound exclusion have longer exclusion period than existing policy Yes / No
(Please indicate 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