Bajaj Allianz General Insurance Co. Ltd.
Bajaj Allianz House, Airport Road, Yerawada, Pune - 411 006. Reg. No.: 113
CIN: U66010PN2000PLC015329 | UIN: BAJHLIP21273V012021 | **UIN - BAJHLIA22169V012122**
For more details, log on to : **www.bajajallianz.com** or
call at : **Sales - 1800 209 0144 / Service - 1800 209 5858** (Toll Free No.)

Caringly yours

BAJAJ | Allianz

Unique Reference Number: BAGIC/ Health/ Individual/ 006

Proposal Form Unique Reference Number: BAGIC/ Health/ Group/ 001								
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.

CRITI CARE - PROPOSAL FORM

Instructions for filling up the 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. T his 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.

Proposer Details

1. **Full Name:**

2. Are you an existing Bajaj Allianz Customer: Yes / No If yes, please mention the Policy No: OG_____

3. Gender: ☐ Male ☐ Female ☐ Other

4. Date of Birth :

5. PAN No:

6. UID/Unique ID:

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_____

11a) Permanent / Residential Address :

House No & Name

Landmark/Locality

Road/Area Name City

State Pin Code

11b) Correspondence Address : (All the communications will be sent to the below address)

House No & Name

Landmark/Locality

Road/Area Name City

State Pin Code

Telephone (Res.) Telephone (Office)

Mobile Number E-Mail _____ @ _____

12. Educational Qualification: ☐ Matriculate ☐ Under Graduate ☐ Graduate ☐ Post Graduate ☐ Professionally Qualified

13. Family Monthly Income: ☐ Up to Rs. 20,000 ☐ Rs. 20,001 to Rs. 50,000 ☐ Rs. 50,001 to Rs. 1 lakh ☐ Above Rs. 1 lakh

14. In case of any Offer, you would prefer to be contacted by: ☐ Phone ☐ Email

15. Nationality

16. Policy tenure: ☐ 1 Yr ☐ 2 Yrs ☐ 3 Yrs

17. Payment mode ☐ Full Payment ☐ Installment Payment

If Installment Payment Mode is opted, please provide below details: ☐ Monthly ☐ Quarterly ☐ Half Yearly ☐ Annual

Details of the persons to be insured

Name	DOB (dd/mm/yy)	Age	Gender (M/F)	Ht	Wt	Occupation	Relation	Nominee	Relationship of Nominee	Gross monthly Income

☐ **Health Prime Rider**

☐ **Individual** ☐ **Floater** Plan Option _____

Bajaj Allianz General Insurance Co. Ltd.

Caringly yours

BAJAJ | Allianz

Section-II Insurance Information

1. Selection of Survival Period and Waiting Period

a. Survival Period- ☐ 0 days ☐ 7 days ☐ 15 days

b. Waiting Period- ☐ 180 day ☐ 120 days

2. Section Opted and Sum Insured (Note: Section(s) selected below will be applicable for all Family Members)

Member Name	Cancer Care	Cardiovascular Care	Kidney Care	Neuro Care	Transplants Care And Sensory Organs Care

3. Do you have other current or pending critical illness Insurance with BAGICL ? YES ☐ NO ☐

If yes Policy No._____

4. Do you have other current or pending critical illness Insurance with another Company? YES ☐ NO ☐

If yes._____

Name of Insurance Company :_____Sum Insured:_____ Year ☐☐☐☐☐☐☐☐

5. Has any proposal for Life, Accident, Disability cover, Critical Illness or any other Health-Related Insurance on your life ever been postponed, declined or accepted on special terms? YES ☐ NO ☐

If yes, give details including amount applied for :_____

6. Have you smoked or used any substance or product containing tobacco, nicotine or marijuana? YES ☐ NO ☐

If yes, please state duration and average daily consumption and type_____

PLEASE 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 YES ☐ NO ☐
(e.g. digestive disorders, gastric or duodenal ulcer, hepatitis B, hepatitis C or other disorders of the liver, disorders of the gall bladder)?

e. Diseases of the nervous system or mental disorders YES ☐ NO ☐
(e.g. stroke, epilepsy, fits or fainting attacks, frequent headaches, 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 ☐

g. Unexplained night-sweats and/or loss of weight, persistent fever, chronic or recurrent diarrhea, unexplained infections or swollen glands? YES ☐ 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 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 ☐

6. 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 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, X-rays, electrocardiograms, ultra sonograms, CT scans or biopsy, other than for routine employment or immigration purposes? YES ☐ NO ☐

8. Have you ever received or do you now receive any personal accident, disability benefit, or disability-related payments? YES ☐ NO ☐

9. Are you at present or any time in past were on any medication, special diet, or treatment? YES ☐ NO ☐

10. Have you ever taken narcotics or other habit forming drugs or been treated or advised in connection with your alcohol consumption 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, hang-gliding, 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 complication during your previous pregnancy/delivery? YES ☐ NO ☐

13. Have you or any of the persons proposed to be insured were/are detected as Covid positive? YES ☐ NO ☐

14. If answer is yes in any of above condition from 3 to 13 please state details in below table

Member Name	Name of Illness/Condition	Medications details	Duration	Vaccinated against COVID-19? (Yes/No)

15. Name and address of your regular medical consultant:_____

_____

16. Payment Mode: ☐ Cash ☐ Cheque ☐ DD ☐ Credit Card ☐ Debit Card

Amount	Transaction No.	Transaction Date	Bank Name	Branch

*DECLARATION

I/ We hereby declare and warrant, on my behalf and on behalf of all persons proposed to be insured, that the declarations, warranties, statements answers and/ or particulars given in this proposal form are complete, true and accurate in all respects to the best of my personal knowledge and belief, and have understood that the statements, answers and/ or particulars given in this proposal form and this declaration shall be held to be promissory and shall be the basis of the insurance contract between me/us and the Company 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 renewals thereof, from time to time, 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 inform in writing to the Company any changes occurring in the occupation or general health of the Insured Person(s) to be insured/ proposer and or any changes in statements answers and/ or particulars mentioned in this proposal form/documents/ risk proposed for insurance at any time after the submission of this proposal form. Upon renewal of Policy, I/We agree to abide by the standard Terms and Conditions of the original policy of the Company, unless otherwise mentioned by the Company in renewal Policy Schedule or attachments thereto.

I/we will accept the usual Conditions and form of the policy issued by Company in such cases. I/we also agree that the contract of Insurance will be effective only upon Company conveying its acceptance of this proposal/renewal proposal, and Company actually receiving or realizing [in case of payment by cheque/DD/POI of prescribed premium amount chargeable, failing which, even if acceptance of proposal of me is intimated to me by the Company, the Company's assumption of risk is void ab initio.

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 with any reinsurer, Governmental and/or Regulatory authority and/or service provider of the Company.

I/We hereby declare that, if it is found that any of the statements answers and/ or particulars in this proposal form or other documents submitted along with this proposal form are incorrect, untrue, forged, suppressed any information or provided misleading/false information in any respect on any material/immaterial matter, to the grant of a risk cover, the Company shall have no liability under the insurance contract or the policy document issued/to be issued.

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.

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. ☐

ACKNOWLEDGEMENT:

Received from Ms. / Mrs. / Mr: _____

sum of Rs._____through Cash# / Cheque / DD / Credit Card / Debit Card No. _____against your proposal for Health Policy.

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