

For Office Use Only :				For Agent Use Only :			
Scrutiny No	Receipt No	Policy Issuing Office	Policy No	IMD Code	Sub IMD Code	IMD Name	Mobile No

SARAL SURAKSHA BIMA, BAJAJ ALLIANZ GENERAL INSURANCE COMPANY LTD. PROPOSAL FORM

Instructions for filling up the FORM:

- Please answer all questions in BLOCK letters.
- The Liability of the Company does not commence until this Proposal has been accepted by the Company and premium has been paid.
- 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.

PROPOSER DETAILS

- Full Name: Title First Name
Middle Name Surname
- Are you an existing Bajaj Allianz Customer: Yes / No If yes, please mention the Policy No: OG _____
- Gender: Male Female Other 4. Date of Birth 5. PAN No
- UID/Aadhaar no. Landmark/Locality
- Bajaj Allianz Employee Code, if Proposer is BAGIC/BALIC Employee
- Marital Status: Married Single Divorced Widowed 9) No. of Children Sons Daughters
- Occupation Business Salaried Professional Student House Wife Retired Others _____

11 a) Permanent / Residential Address

House No. House Name
 Landmark/ Locality
 Road/ Area Name
 City/District
 State
 Pin Code Tel.
 Mobile
 Email

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

House No. House Name
 Landmark/ Locality
 Road/ Area Name
 City/District
 State
 Pin Code Tel.
 Mobile
 Email

- Educational Qualification: Matriculate Under Graduate Graduate Post Graduate Professionally Qualified
- 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
- In case of any Offer, you would prefer to be contacted by: Phone Email 15) Nationality
- Payment Mode: Full Payment Installment Payment (if opted installment payment mode Monthly Quarterly Half Yearly)

DETAILS OF PERSONS TO BE INSURED

Member Details	Relationship with Proposer	Date of Birth	Age	Gender	Occupation	Any Existing Disability / Infirmary	Gross Monthly Income	Nominee	Nominee Relationship with Insured
		DD/MM/YYYY		(M/ F)					

DETAILS OF PERSONS TO BE INSURED

Member Name	Death, Permanent Total Disability and Permanent Partial Disability
	Sum Insured

Optional Cover Details:

You may opt for the following Optional Covers on payment of additional premium.

Member Name	Temporary Total Disablement	Hospitalisation Expenses due to Accident	Education Grant *
	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>

* If opted for Optional Cover Educational Grant, Please provide number of Children- _____

Premium Payment Details:

Mode of Payment :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 insurance policy, is subject to the Board approved underwriting policy of the insurance company and that the policy will come into force only after full receipt 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 life to be insured/ proposer after the proposal has been submitted but before communication of the risk acceptance by the company.

I/ We declare and consent to the company seeking medical information from any doctor or from a hospital who at anytime has attended on the life to be insured/ proposer 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 Governmental and/or Regulatory authority.

Proposed Policy Period: From: ___/___/___ To : ___/___/___

Date ___/___/___

* 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: _____

*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.

Signature (On behalf of Proposer)

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 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 FAULT IN COMPLYING WITH THE PROVISIONS OF THIS SECTION SHALL BE PUNISHABLE WITH FINE WHICH MAY EXTEND TO TEN LAKH RUPEES.