Bajaj Allianz General Insurance Co. Ltd.
Bajaj Allianz House, Airport Road, Yerawada, Pune - 411 006. Reg. No.: 113
CIN: U66010PN2000PLC015329 | UIN: BAJHLIP21117V022021
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

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.

CRITICAL ILLNESS - 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. 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

Proposer Details

1) Full Name: Title _____ First Name _____

Middle Name _____ Surname _____

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 ☐ Other ☐ 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 _____

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 Period: ☐ 1 year ☐ 2 years ☐ 3 years

17) Payment Mode: ☐ Full Payment ☐ Installment Payment (if opted installment payment mode ☐ Monthly ☐ Quarterly ☐ Half Yearly)

Details of the persons to be insured

Sr No	Name	DOB (dd/mm /yy)	Age	Gender (M/F)	Ht	Wt	Occupation	Relation	Premium	Nominee	Relationship of Nominee

Section-II Insurance Information

Critical Illness benefit applied for Rs. _____

Do you have other current or pending critical illness Insurance with BAGICL ? ☐ Yes ☐ No

If yes Policy No. _____

Do you have other current or pending critical illness Insurance with another Company? ☐ Yes ☐ No

If yes: _____

Name of Institution : _____ Sum Insured: _____ Year D D M M Y Y Y Y

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 : _____

Section-III Health Status

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 (e.g. digestive disorders, gastric or duodenal ulcer, hepatitis B, hepatitis C or 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, nervous breakdown, depression or other mental or psychiatric disorder)? ☐ Yes ☐ No
   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?
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 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:_____
14. Name and address of your regular medical consultant:

_____

If you answered "yes" to any of the questions numbered 1 to 13 (in Section 3 Health Status), please give complete details (including dates, duration and treatment, names and addresses of physicians) on the reverse of this form and include your signature and the date.

_____

_____

Payment Details

☐ Cash ☐ Cheque ☐ Cash ☐ DD ☐ Credit Card ☐ Debit Card

Amount	Transaction No.	Transaction Date	Bank Name	Branch

Declaration*

1. 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 by me are true and complete in all respects to the best of my knowledge and that I am authorised to propose on behalf of these other persons.
2. 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 insurer and that the policy will come into force only after full payment of the premium chargeable.
3. 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 proposal has been submitted but before communication of the risk acceptance by the company.
4. 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 to be insured/proposer 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 information from any 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/or claim settlement.
5. I authorize the company to share information pertaining to my proposal including the medical records of the insured/proposer for the sole purpose of underwriting the proposal and/or claims settlement and with any 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 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.

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 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.