

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
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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

- Are you now in good health and entirely free from any mental or physical impairments or deformities? Yes No
- How much weight have you lost or gained over the last 12 months? _____ (Kg.)
Reason for weight change: _____
- Have you ever suffered or do you now suffer from:
 - Diseases of the circulatory system (e.g. heart trouble, chest pain, rheumatic fever, high blood pressure, diseases of the arteries and veins)? Yes No
 - Diseases of the respiratory system (e.g. tuberculosis, asthma, persistent cough, pneumonia or emphysema)? Yes No
 - Diseases of the genito-urinary system (e.g. infections of the kidneys, urinary or genital organs, renal stones, venereal disease)? Yes No
 - 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
 - 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
 - Diabetes mellitus, cancer or tumour of any kind, or any diseases of the blood, glands, spleen, ears, eyes or skin? Yes No
 - Unexplained night-sweats and/or loss of weight, persistent fever, chronic or recurrent diarrhea, unexplained infections or swollen glands? Yes No
 - Any other diseases or ailments not mentioned above? Yes No
- 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
- Have you ever had or been advised to have hospital treatment or surgery? Yes No
- 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
- 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
- Have you ever received or do you now receive any personal accident, disability benefit, or disability-related payments? Yes No
- Are you at present or any time in past were on any medication, special diet, or treatment? Yes No
- 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
- 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
- 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
- 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: _____
- Have you or any of the persons proposed to be insured were/are detected as Covid positive? Yes No
- Name and address of your regular medical consultant : _____

If you answered "yes" to any of the questions numbered 1 to 15 (in Section 3 Health Status), please share details in below table

Name of the person	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)

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.



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.