Bajaj Allianz General Insurance Co. Ltd.
Bajaj Allianz House, Airport Road, Yerawada, Pune - 411 006. Reg. No.: 113
CIN: U66010PN2000PLC015329 | UIN: BAJHLIP23209V022223

For more details, log on to : **www.bajajallianz.com** or
call at : **Sales - 1800 209 0144 / Service - 1800 209 5858** (Toll Free No.)**or 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.

GLOBAL HEALTH 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. 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.

A. 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

10 a) Are you or any of your family members registered under the Ayushmaan Bharat Yojana?If yes please share your Ayushmaan Bharat Health Account Number (ABHA)in the below table ☐ Yes / ☐ No

11 Are you or any of your family members registered under the Ayushmaan Bharat Yojana? Yes/No If yes please share your Ayushmaan Bharat Health Account Number (ABHA)in the below table

House Name _____
Landmark/Locality _____
Road/Area Name _____
City/District _____
State _____ Pin Code _____
Mobile _____ Tel. _____
Email _____

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 _____

Member Name	ABHA Number (14 Digits)	Residential Status (Please mention one of the below options) (Indian residing in India/NRI/ PIO or OCI residing in India/ Expat residing in India)	Country of Residence

B. PREMIUM PAYMENT MODE

16. Payment Mode: ☐ Full Payment ☐ Installment Payment (If opted Installment payment mode) ☐ Monthly ☐ Quarterly ☐ Half Yearly

C. PLAN DETAILS

17. Please select Plan: ☐ Imperial ☐ Imperial Plus 18. Please select area of cover: ☐ Excluding USA ☐ Including USA
19. If you want to opt for Dental Plan Benefits (Optional Cover) ☐ Yes ☐ No 20. If you want to opt for Health Prime (Rider) ☐ Individual ☐ Floater ☐ Plan Option_☐_

D. Details of persons to be insured

Member Name	Relationship with Proposer	Date of Birth DD/MM/YYYY	Age	Gender (M/ F)	Height (cms)	Weight (Kgs)	Nominee	Nominee Relationship with Insured

E. SUM INSURED AND DEDUCTIBLE DETAILS:

IMPERIAL PLAN SUM INSURED OPTIONS (Please tick the required Sum Insured)

Member Name	Domestic SI-INR 3,750,000 International SI- USD 100,000	Domestic SI-INR 5,600,000 International SI- USD 150,000	Domestic SI- INR 7,500,000 International SI- USD 200,000

IMPERIAL PLUS SUM INSURED OPTIONS (Please tick the required Sum Insured)

Member Name	Domestic SI- INR 11,200,000 International SI- USD 300,000	Domestic SI- INR 18,750,000 International SI- USD 500,000	Domestic SI- INR 37,500,000 International SI- USD 1,000,000

Please select deductible option (deductible is applicable only for International Cover) ☐ No deductible ☐ USD 500 ☐ USD 1000

F. MEDICAL DECLARATION:

1. Do you smoke cigarettes or consume tobacco (chewing paste) / alcohol, nicotine or marijuana in any form? Please give duration and daily consumption?_____
2. 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

_____

3. Have you or any of the members proposed to be insured ever had or been told to have or been treated for:

a. epilepsy, fits, stroke, paralysis, weakness of limb, prolonged headache, unconsciousness, nervous breakdown, depression or any other nervous/mental (Psychiatry and psychotherapy) disorders? ☐ YES ☐ NO

b. diabetes, thyroid disorders or any other endocrine disorders? ☐ YES ☐ NO

c. ear discharge, nose bleeds, double vision, impaired sight, hearing, or speech or any other disorders of ear, eye, nose or throat? ☐ YES ☐ NO

d. asthma, persistent cough, coughing with blood, pneumonia, tuberculosis, chest or breathing complaints/discomfort or any other lung disorders? ☐ YES ☐ NO

e. raised cholesterol, high blood pressure, heart attack, heart murmur, cardiomyopathy, mitral valve prolapse or other heart valve disorders, breathlessness, irregular or fast heart rate, chest discomfort or pain, disease of or any other disorders of the heart or blood vessels? ☐ YES ☐ NO

f. gastritis, stomach or duodenal ulcer, blood in stools, fistula, piles or any other stomach or bowel disorders? ☐ YES ☐ NO

g. jaundice, hepatitis B carrier or any form of hepatitis, liver disorder or gall bladder disorder? ☐ YES ☐ NO

h. blood, protein or sugar in urine, kidney stones, infection or any other disorders of the kidney, bladder or genital organs? ☐ YES ☐ NO

i. slipped disc, gout, arthritis, pain or deformity or disorders of the muscles, spine, limbs or joints or severe injury? ☐ YES ☐ NO

j. cancer, tumours, cysts or growths of any kind? ☐ YES ☐ NO

k. anaemia, any other disorders of the blood, advised to abstain from donating blood or received blood transfusion or blood products on account of haemophilia or any other reason? ☐ YES ☐ NO

l. any other illness, disorder, operation, physical disability or accident not mentioned above?

_____

4. 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

5. Do you or any of the family members to be covered have/had any health complaints/met with any accident and have been taking treatment, regular medication (self/ prescribed)or planned for any treatment / surgery / hospitalization? ☐ YES ☐ NO

(Please provide details in the table given below)

If the reply is YES for question 3 and 5 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)
					☐ ☐
					☐ ☐
					☐ ☐
					☐ ☐

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

(If Yes, Give Date of Detection and Treatment Details)_____

G. Payment Details: ☐ **Cash** ☐ **Cheque** ☐ **DD** ☐ **Credit Card** ☐ **Debit Card** ☐ **NEFT**

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/We hereby authorize and give my/our consent to Company to collect my/our personal and medical information/data available in my/our Ayushyman Bharat Health Account (ABHA). Further I/we hereby authorise Company to use/share the information/data, pertaining to my proposal and/or collected from my/our ABHA, with reinsurer, Service Provider and or with any Governmental and/or Regulatory authority, for the sole purpose of proposal underwriting and/or claims settlement and or to comply with applicable laws/regulations.

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: _____

*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.

Signature (On behalf of 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.

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

DECLARATIONS – PHYSICAL PROPOSAL FORM

- Are you or any of the proposal applicants a PEP* or a close relative of PEP*?

  If yes, please share the details _____

  "Politically Exposed Persons" (PEPs) are individuals who are or have been entrusted with prominent public functions in a foreign country, e.g., Heads of States/Governments, senior politicians, senior government/juridical /military officers, senior executives of state-owned corporations, important political party officials, etc." ☐ Yes / ☐ No

- I/we hereby give my/our consent to the Company to verify and obtain my/our identity/address proof through CERSAI records or National Securities Depository Limited Portal for the purpose of undertaking KYC verification. ☐ Yes / ☐ No

- I/we hereby declare and confirm that the premium has been paid out of legally acquired sources of income and the subsequent premiums if any, will continue to be paid out of legally declared and assessed source of income. ☐ Yes / ☐ No

- I/We hereby give voluntary consent to BAGIC/Company to share my/our personal information and data provided in this proposal form with its group companies or any other person in connection with the Insurance Policy or otherwise, including for providing products and services of group companies that may be of interest to me/us, to be used in accordance with their respective privacy policies and subject to appropriate measures being in place to safeguard my/our personal information. ☐ Yes / ☐ No