Bajaj Allianz General Insurance Co. Ltd.

Bajaj Allianz House, Airport Road, Yerawada, Pune - 411006. Reg No.: 113.
CIN: U66010PN2000PLC015329 / UIN: BAJHLIP23211V052223, BAJHLAP21586V012021, BAJHLIA24087V022324, BAJHLIA23141V012223
Email: bagichelp@bajajallianz.co.in | Website: www.bajajallianz.com

Caringly yours

For Office Use Only:

Scrutiny No.	Receipt No.	Policy No.

For Agent Use Only:

Intermediary Name	Intermediary Code

PROPOSAL FORM

Proposal form Unique Reference Number – BAGIC/Health/Individual/001

Health Ensure

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

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/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_____

10 a) 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

11a) 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.(Res.)

Tel.(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 Term ☐ 1 Year ☐ 2 Years ☐ 3 Years

17) Payment mode: ☐ Full Payment ☐ Installment Payment ☐ Monthly ☐ Quarterly ☐ Half yearly (if opted Installment payment mode)

18) Premium Payment Zone to be opted ☐ Zone A ☐ Zone B

There are Two Zones for Premium payment

Zone A: "Following cities has been clubbed in Zone A:-Delhi / NCR, Mumbai including Navi Mumbai, Thane and Kalyan, Hyderabad and Secunderabad, Bangalore, Kolkata, Ahmedabad, Vadodara and Surat.

Zone B: Rest of India apart from Zone A cities are classified as Zone B.

Note:-

- Policyholders paying Zone A premium rates can avail treatment allover India without any co-payment.
- But, those, who pay zone B premium rates and avail treatment in Zone A city will have to pay 20% co-payment on admissible claim amount. This Co – payment will not be applicable for Accidental Hospitalization cases."
- Policyholder residing in Zone B can choose to pay premium for Zone A and avail treatment all over India without any co-payment.

18) Details Of Persons To Be Insured

Member Name	Relationship with Proposer	DOB (dd/mm /yy)	Age	Gender	Ht (cms)	Wt (kgs)	Nominee	Nominee Relationship with Insured

19) Plan Details:

Member Name	ABHA Number (14 Digits)	Sum Insured(individual)	Sum Insured(Floater)	Non-Medical Expenses Cover (Rider)* Yes /No

*Note- 1. This rider can be availed with Sum Insured options of INR 5,00,000 and above on payment of extra premium
2. If opted, this rider will be applicable for all family members falling in the above Sum Insured eligibility criteria.

☐ Health Prime Rider | Co-Pay: ☐ YES ☐ NO

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

20) Respect Rider: ☐ YES ☐ NO (If Respect Rider is opted, please furnish details in the attached annexure)

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

_____

22) 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

_____

23) Has any of the persons to be insured suffer from/or investigated for any of the following? Disorder of the heart, or circulatory system, chest pain, high blood pressure, stroke, asthma any respiratory conditions, cancer tumor lump of any kind, diabetes, hepatitis, disorder of urinary tract or kidneys, blood disorder, any mental or psychiatric conditions, any disease of brain or nervous system, fits (epilepsy) slipped disc, backache, any congenital/ birth defects/ urinary diseases, AIDS or positive HIV. Yes ☐ No ☐

24) Have you or any of the persons proposed to be insured were/are detected as Covid positive? ☐ Yes ☐ No

25) Do you or any of the family members to be covered have/had any health complaints/met with any accident in the past 4 years and prior to 4 years and have been taking treatment, regular medication (self/ prescribed)or planned for any treatment / surgery / hospitalization? (Please provide details in the table given below)
☐ Yes ☐ No

If the reply is YES for question 23 and 25 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)

26) 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

27) 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 Individual Policy/floater Policy, 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 notify in writing any change occurring in the occupation or general health of the Insured Person(s) to be insured/ proposer after the proposal has been submitted but before communication of the risk acceptance by the Company. Upon renewal of Policy, I/We agree to abide by the standard Terms and Conditions, unless otherwise mentioned by the Company in renewal Policy Schedule or attachments thereto.

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 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:

D	D	M	M	Y	Y	Y	Y

Signature/ Thumb Impression of the Proposer

Place: _____

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:

D	D	M	M	Y	Y	Y	Y

Signature
(On behalf of Proposer)

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.

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. ☐

PORTABILITY FORM

PART I

1) Name of the Policyholder / insured (s)_____

2) Date of Birth / Age_____

3) Address of policyholder /insured_____

4) Details of existing insurer

i. Name of the product_____

ii. Sum Insured_____

iii. Cumulative Bonus_____

iv. Add ons/Riders taken_____

v. Policy Number_____

5) Details of the proposed insurance

i. Name of the product proposed/intended to take_____

ii. Sum insured proposed_____

iii. Whether Cumulative Bonus to be converted to an enhanced sum insured_____

6) Reason (s) of portability_____

7) No of family member to be included in the policy to be ported_____

First Name of Insured	Details of previous health insurance policy / Policy number	Health Id card number	Sum Insured	CB	Previous Insurance		First policy inception date
					From dd/mm/yy	To dd/mm/yy	

Enclosure: Photocopy of the existing policy documents

Date ____/ _____/ _____

PART II

1. Whether the PED exclusions / time bound exclusion have longer exclusion period than existing policy

(Please indicate Yes /No) ☐ Yes ☐ No

2. If yes, please give written consent to the declaration below:

"I am aware that the waiting period for the following disease (s)/ treatment (s) is .....days/years more than the previous policy terms, I hereby agree to observe the additional waiting period for the following diseases (s)/ treatments (s)

Signature of Policyholder

ACKNOWLEDGMENT:

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

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

It is mandatory to keep your policy with updated contact (Mobile No., Email ID and PAN Card) and bank account details, to process any of your service requests faster and hassle-free in future.
You can update the same through Caringly yours App – http://onelink.to/v9zp7c , WhatsApp Service {Say 'Hi' on WhatsApp - +91 75072 45858}, Contact our 24-Hour Call Center at 1800-209-5858, 1800-102-5858, Give a Missed Call on – 8080945060, SMS "WORRY" to 575758, Email – bagichelp@bajajallianz.co.in, website – https://www.bajajallianz.com/general-insurance.html , contact your agent or nearest branch.