Bajaj Allianz General Insurance Co. Ltd.
Bajaj Allianz House, Airport Road, Yerawada, Pune - 411 006. Reg. No.: 113
CIN: U66010PN2000PLC015329 | UIN: BAJHLIP21115V022021
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.
					10076960			

HOSPITAL CASH DAILY ALLOWANCE POLICY 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 _____

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_____

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.(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 Period: ☐ 1 year ☐ 2 years ☐ 3 years

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

18) Details of the persons to be insured

Sr No	Name	DOB (dd/mm /yy)	Age	Gender (M/F)	Ht (in Cms)	Wt (in Kgs)	Occupation	Relation	Net Monthly Income	Coverage opted		Premium	Nominee	Relationship of Nominee
										30/60 days	500 /1000 / 2000 /2500 Rs. per day			

19) Period of Insurance: From D D M M Y Y Y Y To D D M M Y Y Y Y

20) Do you smoke cigarettes or consume tobacco (chewing paste) / alcohol, nicotine or marijuana in any form? ☐ Yes ☐ No
Please give duration and daily consumption _____

21) 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, If yes, indicate in the table given below. ☐ Yes ☐ No

22) 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? ☐ Yes ☐ No

Member Name	Relationship with Proposer	Disease Name	At what Age illness suffered

23) Please confirm, if any of the person to be insured is pregnant (For Females Only)If yes, please state how many months?_____
☐ Yes ☐ No

24) 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? ☐ Yes ☐ No
If the reply is YES for question 21 and 24 please share details in below table

Sr. No	Name of the person	Name of the Illness /injury suffered / suffering in the past 4 years	Treatment details	Date first treated	Name of the Illness / injury suffered any time inthe past (prior to 4 years)	Treatment details	Date first treated	Current Status of the Illness/ Diseases/Injury

25) 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_____

26) Family Doctor Details:

Name:

Qualification: Mobile

Address:

Reg No:

27) Payment Details ☐ Cash ☐ Cheque ☐ Cash ☐ DD ☐ Credit Card ☐ Debit Card

Amount	Transaction No.	Transaction Date	Bank Name	Branch

Payment Details
Mode of Payment: ☐ Cheque ☐ DD ☐ Cash ☐ Others
Cheque - Given by: ☐ Spouse ☐ Father ☐ Mother ☐ Son/Daughter ☐ Employer/Employee ☐ Financier

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.** ☐

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 ____/ ____/ _____

Signature/ Thumb Impression of the Proposer

Place :_____

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.

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