Bajaj Allianz General Insurance Co. Ltd.

Bajaj Allianz House, Airport Road, Yerawada, Pune - 411 006. Reg. No.: 113

CIN: U66010PN2000PLC015329 | UIN: BAJHLAP21586V012021, BAJHLIA24087V022324 , IRDA/NL-HLT/BAGI/P-H/V.I/150/13-14, BAJHLIA23141V012223

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

For Office Use Only :			**For Agent Use Only :**	
Scrutiny No.	Receipt No.	Policy No.	Intermediary Name	Intermediary Code

STAR PACKAGE 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 ☐☐/☐☐/☐☐☐☐ 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? ☐ Yes / ☐ No
If yes please share your Ayushmaan Bharat Health Account Number (ABHA)in the below table

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.(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 year ☐ 3 year

17) Plan Details

Minimum three sections to be opted

a) **HEALTH GUARD SECTION**

i) Plan ☐ Silver ☐ Gold ☐ Platinum

ii) Sum Insured options

Health Guard –Silver ☐ ₹ 1,50,000 ☐ ₹ 2,00,000

Health Guard –Gold ☐ ₹ 3,00,000 ☐ ₹ 4,00,000 ☐ ₹ 5,00,000 ☐ ₹ 7,50,000 ☐ ₹ 10,00,000 ☐ ₹ 15,00,000 ☐ ₹ 20,00,000
☐ ₹ 25,00,000 ☐ ₹ 30,00,000 ☐ ₹ 35,00,000 ☐ ₹ 40,00,000 ☐ ₹ 45,00,000 ☐ ₹ 50,00,000

Health Guard –Platinum ☐ ₹ 5,00,000 ☐ ₹ 7,50,000 ☐ ₹ 10,00,000 ☐ ₹ 15,00,000 ☐ ₹ 20,00,000 ☐ ₹ 25,00,000 ☐ ₹ 30,00,000
☐ ₹ 35,00,000 ☐ ₹ 40,00,000 ☐ ₹ 45,00,000 ☐ ₹ 50,00,000 ☐ ₹75,00,000 ☐ ₹ 100,00,000

iii) Voluntary co pay ☐ 10% ☐ 20%

iv) Premium Payment Zones ☐ Zone A ☐ Zone B ☐ Zone C

v) Room Rent Capping : ☐ Yes ☐ No

Note: By Opting for room rent capping option you will be eligible for discount on premium as mentioned in the table below. The room rent would be restricted to 1.5% of the base Sum Insured maximum up to INR 7,500 per day. This discount is applicable for Sum Insured 3 Lacs and above only.

vi) Non-Medical Expenses Cover (Rider) ☐ Yes ☐ No

Note- This rider can be availed with Sum Insured options of INR 5,00,000 and above on payment of extra premium

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

☐ Individual ☐ Floater Plan Option _____

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

b) Please encircle the cover to be opted

Section	Products	Plan A	Plan B	Plan C	Plan D
1	Hospital Cash	500	1000	2000	2500
2	Critical Illness	100000	150000	200000	300000
3	Personal Accident	200000	300000	400000	500000
4	Education Grant	200000	300000	400000	500000
5	Householders contents	100000	200000	300000	400000
6	Traveling Baggage	10000	20000	30000	40000
7	Public liability	200000	300000	400000	500000

c) Total no of sections opted for _____

d) Critical Illness: Please indicate if you want option for family floater ☐ Yes ☐ No

☐ Self + Spouse ☐ Self + Spouse + 1 Child ☐ Self + Spouse + 2 Children

☐ Self + Spouse + 3 Children ☐ Self + Spouse + 4 Children

e) Householders contents (First Loss) Fire perils including earthquake and burglary. Any valuable with value more than 5% of SI under this section to be specifically declared along with value with value otherwise will be excluded .____

18) Details of the persons to be insured

Member Details	Relationship with Proposer	DOB (dd/mm /yy)	Age	Gender (M/F)	Ht	Wt	Occupation	Net Monthly Income	Nominee	Nominee Relationship with Insured

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? Please give duration and daily consumption? ☐ Yes ☐ No

_____

21) 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? ☐ Yes ☐ No

If yes, give details_____

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

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) 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 to 24, please share details in below table

Name of the person	ABHA Number (14 Digits)	Name of the Illness /injury suffered / suffering in the ast 4 years	Treatment details	Date first treated	Current Status of the Illness/ Diseases/Injury	Vaccinated against COVID-19? (Yes/No)

24) 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

25) Payment Mode ☐ Full Payment ☐ Installment Payment

If Installment Payment Mode is opted, please provide below details:

☐ Monthly ☐ Quarterly ☐ Half Yearly ☐ Annual

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 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.

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.** ☐

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