Bajaj Allianz General Insurance Company Limited

Regd. Office & Head Office : GE Plaza, Airport Road, Yerawada, Pune - 411 006.

IMD CODE	
IMD NAME	
MOBILE No.	

PROPOSAL FORM FOR SILVER HEALTH

Important: Please read the following carefully before filling up the proposal form. This proposal for insurance will be the basis of any insurance policy that the Company may issue to you. If there is insufficient space in this proposal for you to provide relevant information, whether as requested or otherwise, please attach a separate sheet to this proposal and return it to us the Company's address specified above.

1. A pre-acceptance health check up is compulsory for all persons proposed to be insured under this policy which will be conducted at a designated diagnostic center. The cover will incept after the acceptance of the proposal based on the test reports

1. Name of the Proposer: Mr./Mrs.

2. Address:

3. City : Pin

4. Phone - Res / Mobile

5. Nationality _____ 6. Monthly Income _____

7. Name and address of the Family doctor _____

8. Telephone No of the Family doctor _____

9. PAN No.

10. Details of the persons to be insured

Sr.	Name	DOB	Age	Gender	Occupation	Height	Weight	Relation	SI	Assignee

11. Details of other Insurance like Mediclaim, Cancer Policy, Critical Illness or any other medical insurance policy (please attach a photocopy)

Policy No.	Name and Address of Insurance Co.	Sum Insured	Period of Insurance		No Claim Bonus %	Claims Received/ Receivable (Rs.)	Claimed for (Nature of Problems)
			From mm/dd/yy	To mm/dd/yy			

Downloaded from www.insureatclick.com - IMD Code : 10000006

12. Do you smoke cigarettes, bidis, or consume tobacco (chewing paste) / alcohol in any form? ☐ Yes ☐ No

Please give duration and daily consumption. _____

13. 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 have been taking treatment / hospitalization? ☐ Yes ☐ No
Please provide the details in the table A given below.

_____

_____

13. Has any of the persons to be insured suffer from / or investigated for any of the following?
Disorder of 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, back ache, any congenital / birth defects/ urinary diseases, AIDS or positive HIV. If yes, indicate in the table given below.

Please specify the period _____

14 Illness / injury details of the past 4 years and prior to 4 yrs

Sr. No.	Name of the Illness / injury suffering from past 4 years	Treatment details	Date first treated	Name of the Illness / injury suffering in the past (prior to 4 years)	Treatment details	Date first treated

15. 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

DECLARATION :

I/We declare and warrant that the information that I/We have given in this proposal in relation to myself/ourselves (or any other person or categories of persons to be insured) and any documentation or information accompanying it or arising out of the answers I/We have given is complete and accurate in all respects. I understand and agree that this proposal and the other information and documentation I have given or will give, relating to myself/ourselves or any other person to be insured, will be the basis of any insurance that you may issue, and I/We also understand the consequences of any default.
I /We are active at work and have not been absent from work due to illness or injury for a continuous period of more than 10 days during the last 2 years.
I/We and /or the person to be insured hereby consent and authorize you or your representative to seek to seek medical information from any Hospital / Medical Practitioner Doctor from which or whom I/ We and / or the person to be insured have at any time sought or shall seek medical attention concerning any disease, sickness, ailment, or injury which affects my/our and /or the person to be insured's physical or mental health.
I/ We, hereby authorize Bajaj Allianz to pay any claim payable to me under the Silver Health Plan to the above named assignee whose discharge will be considered as the full and final discharge on my behalf.

Period of insurance from ☐☐☐☐☐☐☐☐ ending on ☐☐☐☐☐☐☐☐

APPLICANT'S SIGNATURE _____ DATE (DD/MM/YY) _____

\IMPORTANT:

1. It is essential that you answer fully and accurately all of the questions contained in this proposal, and that you provide us with any and all additional information relevant to the risk to be insured or our decision as to the acceptance of the risk or the terms upon which it should be accepted. Your failure to comply with this obligation now may result in the rejection of any claim and the avoidance of your rider when a claim is made. If you are in any doubt about the information to be given, please seek the advice and guidance of your insurance advisor or agent.

2. No insurance cover will be in force until the Company has approved the Proposal and the rider premium due has been paid.
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 a policy accept any rebate, excepts 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 FIVE HUNDRED RUPEES.

Downloaded from www.insureatclick.com - IMD Code : 10000006