IMD CODE										
IMD NAME										
MOBILE No.										

BAJAJ | Allianz

Bajaj Allianz General Insurance Company Limited

STAR PACKAGE POLICY - PROPOSAL FORM

Important: This proposal for insurance will be the basis of any subsequent insurance policy that we issue to you. 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 your claim and the avoidance of your policy 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. 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.

PLEASE ANSWER EVERY QUESTION AND FULLY

Proposer Details :

1. Name of the Proposer

2. Address Res :

City State

PIN Resi./ Mobile

3. E-mail ID _____

4. Name and address of the Family Doctor _____

_____ Tel. No. _____

5. Occupation _____ Nationality _____

6. Monthly income _____ 7. Marital Status : Married ☐ / Single ☐ / Divorced ☐ / Widowed ☐

8. Coverage - Minimum three sections to be opted. 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	Health Guard	100000	200000	300000	500000
3	Critical Illness	100000	150000	200000	300000
4	Personal Accident	200000	300000	400000	500000
5	Education Grant	200000	300000	400000	500000
6	Householders contents	100000	200000	300000	400000
7	Traveling Baggage	10000	20000	30000	40000
8	Public liability	200000	300000	400000	500000

9. Please select the add on covers for Health Guard section (Optional)

S No	Add on coverage	Add. Prem. HG Section	Please tick the option
1	Accommodation to Relative Rs.500/- per day for 10 days	(25 %)	
2	Organ Transplant expenses of donor up to Rs.100,000/-	(25 %)	
3	Accidental Emergency, Reconstructive Surgery (In case of accident), Physiotherapy, Medical evacuation upto Rs.50,000/-	(10%)	
4	Burial, Cremation Expenses Rs.25000/-	(10%)	
5	Medical expenses for accidental hospitalization SI under health guard would double for accidental hospitalization and related surgeries	(25 %)	

10. Critical Illness : Please Indicate if you are opting for Family Floater: Yes ☐ / No ☐

(i) Self +Spouse ☐ (ii) Self + Spouse + 1 Child ☐ (iii) Self + Spouse + 2 Children ☐

(iv) Self + Spouse + 3 Children ☐ (v) Self + Spouse + 4 Child ☐

11. Total No of sections opted for _____

12. Details of the persons to be insured

Sr. No.	Name	DOB	Age	Gender	Ht.	Wt.	Relation

13 Please confirm since how many years you are covered under Health Insurance _____ Years Please attach all the policy copies

14 Details of current health insurance policy /previous health insurance policy / 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			Claims Received / Receivable (Rs.)	Claimed for (Nature of Problems)
			From dd/mm/yy	To dd/mm/yy	No Claim Bonus %		

15 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 otherwise will be excluded. _____

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

Please give duration and daily consumption. _____

17 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 given below.

18 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 _____

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

Sr. No.	Name	Name of the illness/ injury suffered / suffering from past 4 yrs	Treatment details	Date first treated	Name of the illness / Injury suffered / suffering in the past (prior to 4 yrs)	Treatment details	Date first treated

20 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 _____

8.

Name	Assignee*	Name of assignee	DOB/Age	Relation*	% of Sum Insured
Self	Assignee 1				
	Assignee 2				
	Assignee 3				
	Assignee 4				

*Assignee for self has to be one of the below mentioned relations.
"Father, Mother, Son, Daughter, Spouse, Financier, Employer & Others"

If Assignee is "Others" please specify ----------.

(For members other than Self 100 % assignment to the Proposer only)

Declaration: I here by declare and warrant that the above statements are true and complete in all respects and that there is no other information which is relevant to my application for insurance for my insurance , that has not been disclosed to you. I agree that this proposal and the declarations shall be the basis of the contract between me and Bajaj Allianz and I agree to accept a policy, subject to conditions prescribed by Bajaj Allianz.

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

Period of Insurance starting from ☐☐☐☐☐☐☐☐ TO ☐☐☐☐☐☐☐☐

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, except such rebate as may be allowed in accordance with the published prospectus or tables of the insurer. ANY PERSON MAKING FAULT IN COMPLYING WITH THE PROVISIONS OF THIS SECTION SHALL BE PUNISHABLE WITH FINE WHICH MAY EXTEND TO FIVE HUNDRED RUPEES.

Annexure – Critical Illness Questionnaire

(To be filled only if Section III – Critical Illness Opted For)
Individual forms to be filled for every person covered

APPLICANT DETAILS AND PROOF OF AGE

Name : Mr./ Mrs.…….....……..……...

(Surname) (First Name)

Gender: Male ☐ Female ☐ Birth Date: ☐☐☐☐☐☐☐☐

Marital Status : Married ☐ / Single ☐ Divorced ☐ / Widowed ☐

Please provide a copy of any of the following documents as proof of age:

PASSPORT ..... ☐

MUNCIPAL BIRTH CERTIFICATE ..... ☐

SCHOOL OR COLLEGE CERTIFICATE ..... ☐

IDENTITY CARD ..... ☐

PAN CARD ..... ☐

OTHERS PLS SPECIFY ..... ☐

OTHER INSURANCE DETAILS :

Do you have other current or pending critical illness/health insurance/Hospital Cash Policy with BAGICL? Yes ☐ / No ☐

If yes, policy number:…….

Do you have other current or pending any of the above insurance policy with another company? Yes ☐ / No ☐

If yes: Name of Company……..……..…….. Sum Insured……..

Period of Cover……

Has any proposal for life, medical, health, accident, disability cover, critical illness or any other health-related insurance on your life ever been postponed, declined or accepted on special terms? Yes ☐ / No ☐

If Yes, Give Details including amount applied for……

……...

HEALTH STATUS :

PLEASE ANSWER ALL QUESTIONS BY CHECKING EITHER THE YES OR NO BOX

Are you now in good health and entirely free from any mental or physical impairments or deformities ? Yes ☐ / No ☐

Height…… … (Cms) Weight……..(Kg.)

How much weight have you lost or gained over the last 12 months? …… (Kg.).

Reason ..... for ..... weight

Change……..……..……..……..…

Have you ever suffered or do you now suffer from:

- Diseases of the circulatory system (e.g. heart trouble, chest pain, rheumatic fever high blood pressure, diseases of the arteries and veins or any other)? Yes ☐ / No ☐
- Diseases of the respiratory system (e.g. tuberculosis, asthma, persistent cough, pneumonia of emphysema of any other)? Yes ☐ / No ☐
- Diseases of the genitor-urinary system (e.g. infections of the kidneys, urinary or genital organs, renal stones, venereal disease)? Yes ☐ / No ☐
- Diseases of the gastrointestinal system (e.g. digestive disorders, gastric or Yes ☐ / No ☐

duodenal ulcer, hepatitis B or other disorder of the liver, disorders of the gall bladder)?

- Diseases of the nervous system or mental disorders (e.g. stroke, epilepsy, fits or fainting attacks, frequent headaches, nervous breakdown, depression or other mental or psychiatric disorder)? Yes ☐ / No ☐
- Diabetes mellitus, cancer or tumour of any kind, or any diseases of blood, glands, spleen, ears, eyes or skin? Yes ☐ / No ☐
- Unexplained night-sweats and/or loss of weight, persistent fever, chronic or recurrent diarrhea, unexplained infection or swollen glands? Yes ☐ / No ☐
- Any Congenital/birth defects/diseases? Yes ☐ / No ☐
- Any other diseases or ailments not mentioned above? Yes ☐ / No ☐
  Give details……..……..……..
- Have you or any of your immediate family members (father, mother, brother, or sister) have/had cancer, heart attack, or stroke and at what age? Prior to age 60? Yes ☐ / No ☐
- Have you ever had or been advised to have hospital treatment or surgery? Yes ☐ / No ☐
- Have you ever had or been advised to have a blood test for AIDS or An AIDS related condition or have you ever been refused as a blood donor? If Yes: Result of the Blood Test Yes ☐ / No ☐

  Test:……..……..……..……..……..……..……

- In the past 5 years, have you consulted a physician for any reason or have you had any investigation such as blood or urine tests, X-rays, electrocardiograms, ultra sonogram, CT scans or biopsy, other than for routine employment or immigration purposes? Yes ☐ / No ☐
- Have you ever received or do you now receive any disability benefit, disability pension, or disability related payments? Yes ☐ / No ☐
- Are you at present on any medication, special diet, or treatment? Yes ☐ / No ☐
- Have you ever taken narcotics or other habit forming drugs or been treated or advice in connection with your alcohol consumption or the taking of drugs? Yes ☐ / No ☐
- Do you participate or do you intend to participate in any hazardous sports or activities such as motor sports, climbing, parachuting, hang-gliding, or aviation except as a fare-paying passenger? Yes ☐ / No ☐
- Are you pregnant (for female only)? If yes, please state how many months. Yes ☐ / No ☐
- Have you smoked or used any substance or product containing tobacco, nicotine or marijuana in any for in the last 12 months? Yes ☐ / No ☐
  If yes, please state duration and average daily consumption and type :

  ……

  Name and address of your regular medical consultant/Family Physician:

  ……

  ……

If you answered "yes" to any of the questions numbered 1 to 13 (in Section 3 Health Status), please give complete details (including dates, duration and treatment, names and addresses of physicians)

Date_____ Signature_____