



**PROPOSED POLICY DETAILS (Please provide details of your proposed policy)**

Type:  Individual  Floater Proposed Policy Start Date:  |  |  |  |  |  |  |  |  |  Time:.....hrs .....mins Policy Duration:  1 Year  2 Years

Default zone of cover is based on your location. To avail treatment outside your zone, a co-payment will apply. For complete details on classification of zone & applicable co-pay please refer to Product Brochure.

Is All India Coverage required?  Yes  No (Option for persons in Zone II & III)

Note: Persons opting for All India Cover can avail treatment anywhere in India irrespective of the location of residence.

**PROPOSED INSURED(S) INFORMATION\* (Please provide more details of the persons who are being covered in this policy)**

| Sr.No. | Name (First, Middle & Last) | Relationship with Proposer | Date of Birth (DD/MM/YY) | Gender | Pincode# | Profession/ Occupation | Name of Pre-existing illness (If any) | Height (in cms) | Weight (in kgs) | Sum Insured | Name of the Nominee/Relationship | Roll over from previous insurer Yes / No |
|--------|-----------------------------|----------------------------|--------------------------|--------|----------|------------------------|---------------------------------------|-----------------|-----------------|-------------|----------------------------------|--|
| 1.     |                             |                            |                          |        |          |                        |                                       |                 |                 |             |                                  |  |
| 2.     |                             |                            |                          |        |          |                        |                                       |                 |                 |             |                                  |  |
| 3.     |                             |                            |                          |        |          |                        |                                       |                 |                 |             |                                  |  |
| 4.     |                             |                            |                          |        |          |                        |                                       |                 |                 |             |                                  |  |
| 5.     |                             |                            |                          |        |          |                        |                                       |                 |                 |             |                                  |  |

\*Pincode - Please provide pincode of the area where the family member resides. Where all India cover is opted pincode is not mandatory.

**MEDICAL & LIFESTYLE INFORMATION\* (Please answer questions related to your medical history)**

Medical History: Please answer the below mentioned questions in Yes (Y) / No (N). If the answer to any of the questions is Yes, please give details in the table given. Alternatively attach a separate sheet of paper.

- Does any person, proposed to be insured, suffer from or have been treated for any heart related ailment / blood pressure?  Yes  No
- Does any person, proposed to be insured, suffer from Diabetes/Asthma/Epilepsy?  Yes  No
- Does any person, proposed to be insured, suffer from any other disease/ailment?  Yes  No
- Is any person, proposed to be insured, receiving any treatment/medication or have in the past received treatment or undergone surgeries for any medical condition/disability?  Yes  No

Please provide details of hereditary medical history, if any:.....

\_\_\_\_\_  
Signature of Proposer

If answer to the above questions Yes, please elaborate:

| Sr.No. | Name of the person proposed to be insured | • Name of illness/injury suffering from or suffered in the past<br>• Treatment/medication received/receiving | Date first diagnosed/treated | Name of attending Medical Practitioner/ Surgeon with address & Tel. No./Hospital details | Whether fully cured |
|--------|---|--|------------------------------|--|---------------------|
| 1.     |   |  |                              |  |                     |
| 2.     |   |  |                              |  |                     |
| 3.     |   |  |                              |  |                     |
| 4.     |   |  |                              |  |                     |
| 5.     |   |  |                              |  |                     |

**PREVIOUS / CURRENT INSURANCE DETAILS (Please enter previous/current insurers details)**

Does the proposer or the person(s) proposed to be insured currently have an existing insurance cover or have been insured in the past under a Mediclaim, Critical illness, Accident or any other Medical Insurance Policy (Individual or Group)?

If Yes, please provide the details:

| Sr. No.# | Policy No. | Insurer | From Date | To Date | Sum Insured | Claim Details |        |         | Cumulative Bonus Earned |            |
|----------|------------|---------|-----------|---------|-------------|---------------|--------|---------|-------------------------|------------|
|          |            |         |           |         |             | No. of Claims | Amount | Ailment | %                       | Amount (₹) |
| 1.       |            |         |           |         |             |               |        |         |                         |            |
| 2.       |            |         |           |         |             |               |        |         |                         |            |
| 3.       |            |         |           |         |             |               |        |         |                         |            |
| 4.       |            |         |           |         |             |               |        |         |                         |            |
| 5.       |            |         |           |         |             |               |        |         |                         |            |
| 6.       |            |         |           |         |             |               |        |         |                         |            |

\*Sr.No. – Please maintain the same serial order as on page 2

**PREMIUM PAYMENT DETAILS (Please provide the details of premium payment)**

Premium Amount: ₹  Payment Option:  Cash#  Cheque  DD  Credit / Debit Card

Amount in words: .....

\*Cash towards premium upto ₹ 50,000 will be accepted only at our branch offices.

For Cheque / DD (Payable in favour of "L&T General Insurance Company Limited")

Instrument No.:  Instrument Date:  Instrument Amount: ₹

Bank Name:

For Credit Card / Debit Card

Card No.:  Card Type:  Master  Visa  AMEX

Expiry Date:  Name on Card:

(Only Proposer's Card to be accepted)

 **L&T Insurance** is the brand of L&T General Insurance Company Limited Registered Office: L&T House, N.M. Marg, Ballard Estate, Mumbai - 400001. Insurance is the subject matter of solicitation. IRDA Reg. No. 146



**ACKNOWLEDGEMENT**

**my:health**

Received from Ms / Mrs / Mr \_\_\_\_\_

a sum of ₹ \_\_\_\_\_ through Cash#/Cheque/DD/Credit Card/Debit Card No. \_\_\_\_\_

against your proposal for my:health Medisure Prime Insurance

Signature of L&T official / Intermediary: \_\_\_\_\_ Date:

Neither the submission of a completed proposal for insurance or any payment for any policy sought, nor does issuance of a policy kit oblige the Company to agree to issue a policy, which decision is and always shall be in the Company's sole and absolute discretion.

If the Company accept's a proposal for insurance, it shall be subject to the policy terms and conditions and the Company shall have no liability to make any payment if premium is not received by the Company in full and in time, or is not realised.

If a proposal is not accepted, the Company will inform you and refund any payment received from you without interest.

L&T official / Intermediary Name: \_\_\_\_\_ Time:

Place \_\_\_\_\_

\* Cash towards premium upto ₹ 50,000 will be accepted only at our branch offices.

Branch Code: \_\_\_\_\_

Intermediary Code\*: \_\_\_\_\_

Intermediary Location Code: \_\_\_\_\_

Intermediary Employee Code: \_\_\_\_\_

Intermediary Reference Code: \_\_\_\_\_

Intermediary Contact Details: \_\_\_\_\_

DECLARATION

I hereby declare and confirm that the statements in the proposal form are true and complete in all respects and that there is no other information which is relevant to my proposal for taking insurance for myself or my family members to be insured that has not been disclosed to you. I have read the Prospectus and I agree to take the policy, subject to the terms, conditions and exceptions stated therein. I agree and understand that this proposal and the declarations shall be the basis of the contract between me and L&T General Insurance Company Limited should the insurance be effected, and that if, after the insurance is effected, it is found that any of the statements, answers or particulars are incorrect or untrue in any respect, the Company shall have no liability under this insurance.

Please put a (√) to provide consent against the items listed below:

- I consent and authorize L&T General Insurance Company Limited to seek medical information from any Hospital/Medical practitioner who has at any time attended or may attend concerning any disease or illness which affects my or my family members physical or mental health and is concerned with respect to issuance of cover and subsequent claim management under this policy.
- I further authorize L&T General Insurance Company Limited to use and disclose any personal information collected or available with L&T General Insurance Company Limited (whether contained in this application or otherwise obtained) to underwriting companies, claims investigation companies / agencies and insurance / reinsurance companies for the purpose of processing of this Application and providing subsequent services.
- I consent to receive information from the Company through electronic and telecommunication means from time to time.

AUTO RENEWAL CONSENT

- I hereby authorise L&T General Insurance Company Limited to charge premium for me and my family member's policy to my above mentioned Visa/Master Card and renew the policy (Subject to Conditions) every year till further written notification and so long as my Visa/Master card is valid. I understand that my cover would start on remittance being received by L&T General Insurance Company Limited from the bank.

Date: ..... Time: .....

Signature of Proposer

PROHIBITION OF REBATES – UNDER SECTION 41 OF INSURANCE ACT 1938

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 prospectuses 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 ₹ 500/-

 **L&T Insurance** is the brand of L&T General Insurance Company Limited Registered Office: L&T House, N.M. Marg, Ballard Estate, Mumbai - 400001. Insurance is the subject matter of solicitation. IRDA Reg. No. 146



Toll Free Number  
1800-209-5846 (1800-209-LTIN)



Website  
www.ltinsurance.com



SMS  
'LTI' to 5607058 (56070LT)

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Corporate Office: L&T General Insurance Company Limited, 601-602, 6th Floor Trade Center, Bandra Kurla Complex, Bandra (East), Mumbai 400051.

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