Max Bupa
Health Insurance

Health Assurance Proposal Form

Please fill up this form in CAPITAL LETTERS for yourself and each Proposed Insured person.

1. Proposer* Details:

First Name

Middle Name **Last Name**

Permanent Address

City **District**

State **Pin Code**

Current Address

City **District**

State **Pin Code**

Address for Communication ☐ Permanent ☐ Current

Phone No. STD Code Landline No. Mobile No.

E-mail ID (Atleast one mobile no./email ID to be provided)

PAN No. (of Premium Payer) (Mandatory for premium above Rupees 1 lac)

Nationality

Bank Details:

Bank Name

Branch

City

Account Number

Account Type ☐ Savings ☐ Current

* Proposer has to be covered under the insurance Policy and he/she has to be more than 18 years of age.

A Max India Joint Venture

Coverage Selection:

Benefit Type (Please tick the relevant boxes. You can choose multiple benefits)

Critical Illness ☐ Personal Accident ☐ Hospital Cash ☐

Sum Assured (in Rs) (Please tick the relevant boxes)

	Level 1	Level 2	Level 3	Level 4
Critical Illness	☐ 3 lacs	☐ 5 lacs	☐ 7.5 lacs	☐ 10 lacs
Personal Accident#	☐ 5 lacs	☐ 10 lacs	☐ 20 lacs	☐ 25 lacs
Hospital Cash	☐ 1,000/day	☐ 2,000/day	☐ 3,000/day	☐ 4,000/day

Maximum Sum Assured that can be opted would be up to 8 times the annual income of the Proposer

1. Plan details (Please tick the relevant boxes)

Policy Type ☐ Individual ☐ Family Option$

If Family Option, number of persons to be covered (under Hospital Cash and Personal Accident) ☐ 1 Adult + 1 Child ☐ 1 Adult + 2 Children ☐ 2 Adults ☐ 2 Adults + 1 Child ☐ 2 Adults + 2 Children

$ only 2 Adults option available under Critical Illness cover

2. Proposed Policy term (Please tick the relevant box)

☐ 1 year ☐ 2 years

3. Details of the Proposed Insured person 1 (Proposer)

First Name ____________________

Middle Name ____________________ **Last Name** ____________________

Gender ☐ Male ☐ Female **Height** (cm) ____ **Weight** (kgs) ____ **Date of Birth** DD MM YYYY

Educational Qualification ☐ Non-matric ☐ Matric ☐ Graduate ☐ Post Graduate ☐ Professional Course ☐ Other

Occupation

(Please tick the relevant box)

☐ Type 1 - Senior Management, Directors, MD's, CFO's, AVP's, VP's, Senior Managers with no exposure to outside office

☐ Type 2 - Professional Staff with no exposure to activities outside office (like doctors/dentists, lawyers, accountants, actuaries, engineers, teachers etc.)

☐ Type 3 - Partners and Associates with no exposure to activities outside office

☐ Type 4 - Middle or Junior Management

☐ Type 5 - Secretarial and clerical/administrative staff

☐ Type 6 - Business services (advertising, employment agencies, data processing, office equipment etc.)

☐ Type 7 - Senior Management with some exposure to activities outside office (not municipalities)

☐ Type 8 - Professional staff with some exposure to work outside office (surveyors, geologists etc.)

☐ Type 9 - Partners and Associates with some exposure to activities outside office

☐ Type 10 - Professional salespersons (without any travel or delivery job)

☐ Type 11 - Retail Business (Owners of shops/commercial spaces)

Annual Gross Income* (Rs.) ____________________

Annual Gross Income* (in Rs.) - in words ____________________

* For salaried on CTC (Cost to Company) and for self employed net profit as filed in last Income Tax Return

Note: Maximum Sum Assured that can be opted under Personal Accident cover, would be up to 8 times the annual gross income of the Proposer.

Details of the Proposed Insured person 2 (Spouse)

First Name ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Middle Name ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ **Last Name** ☐☐☐☐☐☐☐☐☐☐☐☐☐

Gender ☐ Male ☐ Female **Height** (cm) ☐☐☐ **Weight** (kgs) ☐☐☐ **Date of Birth** D D M M Y Y Y Y

Educational Qualification ☐ Non-matric ☐ Matric ☐ Graduate ☐ Post Graduate ☐ Professional Course ☐ Other

Occupation

(Please tick the relevant box)

- ☐ Type 1 - Senior Management, Directors, MD's, CFO's, AVP's, VP's, Senior Managers with no exposure to outside office
- ☐ Type 2 - Professional Staff with no exposure to activities outside office (like doctors/dentists, lawyers, accountants, actuaries, engineers, teachers etc.)
- ☐ Type 3 - Partners and Associates with no exposure to activities outside office
- ☐ Type 4 - Middle or Junior Management
- ☐ Type 5 - Secretarial and clerical/administrative staff
- ☐ Type 6 - Business services (advertising, employment agencies, data processing, office equipment etc.)
- ☐ Type 7 - Senior Management with some exposure to activities outside office (not municipalities)
- ☐ Type 8 - Professional staff with some exposure to work outside office (surveyors, geologists etc)
- ☐ Type 9 - Partners and Associates with some exposure to activities outside office
- ☐ Type 10 - Professional salespersons (without any travel or delivery job)
- ☐ Type 11 - Retail Business (Owners of shops/commercial spaces)
- ☐ Type 12 - Housewife

Details of the Proposed Insured person 3 (Child 1)

First Name ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Middle Name ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ **Last Name** ☐☐☐☐☐☐☐☐☐☐☐☐☐

Gender ☐ Male ☐ Female **Height** (cm) ☐☐☐ **Weight** (kgs) ☐☐☐ **Date of Birth** D D M M Y Y Y Y

Relationship ☐ Son ☐ Daughter

Educational Qualification ☐ Non-matric ☐ Matric ☐ Graduate ☐ Post Graduate ☐ Professional Course ☐ Other

Details of the Proposed Insured person 4 (Child 2)

First Name ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Middle Name ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ **Last Name** ☐☐☐☐☐☐☐☐☐☐☐☐☐

Gender ☐ Male ☐ Female **Height** (cm) ☐☐☐ **Weight** (kgs) ☐☐☐ **Date of Birth** D D M M Y Y Y Y

Relationship ☐ Son ☐ Daughter

Educational Qualification ☐ Non-matric ☐ Matric ☐ Graduate ☐ Post Graduate ☐ Professional Course ☐ Other

Note: Proposer is liable to inform Max Bupa if there is any change in the nature of job of any of the Insured Persons during the Policy period.

4. Nomination

In the event of the death of the Proposer, any payment due under the Policy shall become payable to the Nominee proposed in the form, subject to any change in nomination per the terms of the Policy. Nominee for all other persons proposed to be insured shall be the proposer himself/herself.

Following section to be filled by the Proposer:

Nominee Name	Relationship with the Proposer	Address & contact details of the Nominee
First Name:______		Address:______
Middle Name:______		______
Last Name:______		Phone No.:______

5. Medical History

In order to help us to service you fully, please answer the questions below accurately to the best of your knowledge in respect of each person proposed to be insured.

Please ensure that you are fully informed about the standard waiting periods and permanent exclusions that apply to the Max Bupa Health Insurance Policies.

To be filled if opting for Critical Illness cover (available only for Adults)

Questions (please answer Yes/No)	Insured 1 (Proposer)	Insured 2 (Spouse)
1. In the past 5 years, have you ever undergone any surgical operations? Are you presently on any treatment or plan to have any surgical operation(s)?		
2. In past 5 years, have you been told by a medical practitioner to undergo any medical investigation or evaluation such as ECG, X-ray (excluding cases of fractures), Biopsy, Blood test for Aplastic Anaemia, MRI, CT scan, pap smear or Urine test for kidney failure with adverse results?		
3. Have any member of your immediate family e.g. parents, brothers or sisters suffered from heart disease, stroke, cancer, kidney failure, organ transplant or any other disease which is persistent/long lasting in nature or any hereditary conditions before the age of 60 yrs?		
4. Have you ever had or been told you have or been treated for any disability or medical conditions such as but not limited to high cholesterol, high blood pressure, chest pain, heart attack or any other heart condition; stroke, transient ischemic attack or any other cerebrovascular disease; diabetes or any other endocrinal disease; kidney disease; HIV/AIDS or AIDS related complex; any cancer or tumor; asthma or any other respiratory disease; any mental or nervous disease; hepatitis A/B or any other liver disease; blood disorder; frequent digestive and bowel disorder (approx. twice every week); paraplegia or any other disorder of the bones, spine or muscle?		
5. Have you ever been advised by a medical practitioner to stop or reduce the consumption of cigarette or any other nicotine product or alcohol or any other drug?		
6. Has the cover for any of the Proposed Insured ever been declined, deferred, withdrawn, accepted at extra premium or reduced cover for 'reinstatement for life insurance'/ 'health insurance'/ 'accident insurance' with any insurance company (including Max Bupa) based on medical conditions?		

Note: In addition to the above, we may ask you to undergo medical tests to complete your full medical assessment. There could be certain declined risks as per underwriting norms of the company.

Please note that incorrect disclosure for the above questions might lead to rejection of claims due to non-disclosure.

To be filled if opting for Hospital Cash cover

Questions (please answer Yes/No)	Insured 1 (Proposer)	Insured 2 (Spouse)	Insured 3 (Child 1)	Insured 4 (Child 2)
1. Do you or any of the Proposed Insured have any existing condition(s) or symptom(s) for which medical advice was recommended or for which consultation was had with doctor for treatment, medical investigation or surgery or required hospitalization in the last 5 years, except for minor ailments like cough, cold or flu.				
2. Have you or any of the Proposed Insured ever been diagnosed with, treated for or advised to seek treatment for any for heart disease, diabetes/raised blood sugar, high blood pressure/hypertension, paralysis, cancer, kidney disease, liver or disease of stomach and intestine, brain or lung disease, mental illness, physical deformity, or HIV / AIDS?				

There could be certain declined risks as per underwriting norms of the company.

To be filled if opting for Personal Accident cover

Questions (please answer Yes/No)	Insured 1 (Proposer)	Insured 2 (Spouse)	Insured 3 (Child 1)	Insured 4 (Child 2)
1. The Proposed Insured is in good health and is not suffering from any injury, illness or disease and does not have any physical impairment, deformity or disability				

There could be certain declined risks as per underwriting norms of the company

6. Others - Applicable for all covers (Critical Illness, Hospital Cash and Personal Accident)

In the past 48 months, have you/other proposed family members ever suffered from any symptom of diseases/illness/or sustained any accident and/or been diagnosed with any disease/illness or have received any treatment for any disease/illness?

(Yes/No) ____

Sr No.	Name of Proposed Insured	Name of illness/disease/injury	Treatment received	Date first treated

For all Insured Persons (opting for **Hospital Cash Cover**) from commencement of the first Policy Period, the conditions listed below will be subject to a waiting period of 24 months and will be covered from the commencement of the third Policy Year as long as the Insured Person has been insured continuously under the Policy without any break.

• Stones in biliary and urinary systems • Lumps / cysts / nodules / polyps / internal tumours • Gastric and Duodenal Ulcers • Surgery on tonsils / adenoids • Osteoarthrosis / Arthritis / Gout / Rheumatism /Spondylosis / Spondylitis / Intervertebral Disc Prolapse • Cataract • Fissure / Fistula / Haemorrhoids • Hernia / Hydrocele / Varicocoele / Spermatocoele • Chronic Renal Failure or end stage Renal Failure • Sinusitis / Deviated Nasal Septum / Tympanoplasty / Chronic Suppurative Otitis Media • Benign Prostatic Hypertrophy • Knee/Hip Joint replacement • Dilatation and Curettage • Varicose veins • Dysfunctional Uterine Bleeding / Fibroids / Prolapse Uterus / Endometriosis • Diabetes and related complications • Hysterectomy for any benign disorder • Thyroid and parathyroid gland disorder excluding malignancy • High Blood Pressure and its complications, direct results of or accompanied by it including but not limited to stroke, cerebral hemorrhage • Any heart, heart valves or coronary disorders.

The following are the permanent exclusions under **Hospital Cash Cover** (for complete details on the exclusions, please refer to the terms and conditions of the Policy).

• Any treatment/surgeries/procedures taking place due to any pre-existing illness/ailment/diseases. All pre-existing conditions declared at the time of application and underwritten by company will be covered after 4 years of continuous coverage • Hospitalization not in accordance with the diagnosis and treatment of the conditions for which the hospital confinements was required • Hospitalization and/or treatment within the waiting period and hospitalization and/or treatment following the diagnosis within the waiting period • Elective surgery or treatment which is not medically necessary • Treatment for weight reduction or weight improvement regardless of whether the same is caused (directly or indirectly) by a medical condition • Any dental care or surgery of cosmetic nature, extraction of impacted tooth/teeth, orthodontics or orthognathic surgery or tempero-mandibular joint disorder except as necessitated by an accidental injury • Treatment of infertility or impotency, sex change or any treatment related to it, abortion, sterilization and contraception including any complication relating thereto • Treatment arising from pregnancy and it's complications which shall include childbirth or miscarriage excluding ectopic pregnancy • Congenital disorder • Hospitalization primarily for diagnosis, X-ray examinations, general physical or medical check-up not followed by active treatment during hospitalization period • Stay in hospital where no active regular treatment is given by specialist medical practitioner • Experimental or unproven procedures • Treatment under any system other than allopathy • Treatment of any mental or psychiatric conditions including but not limited to insanity, mental or nervous breakdown/disorder, depression, dementia, Alzhemer's disease • Admission to a nursing home or home for the care of the aged unless related to the treatment of an acute medical condition • Treatment directly or indirectly arising from alcohol, drug or substance abuse • War, invasion, act of foreign enemy, hostilities, armed or unarmed truce, civil war, mutiny, rebellion, revolution, military or usurped power, riots or civil commotion, strikes and full time service in any of the armed forces • AIDS/HIV • Sexually transmitted diseases • Cosmetic or plastic surgery except to the extent that such surgery is necessary for the repair of damage caused solely by accidental injuries • Nuclear disaster, radioactive contamination and/or release of nuclear or atomic energy • Self-inflicted injury • Any breach of law with criminal intent • Treatment of physical injury caused by engaging in or taking part in professional sport(s) or any hazardous pursuits, including but not limited to driving or riding any kind of race; underwater activities involving the use of breathing apparatus or not; martial arts; hunting; mountaineering; parachuting; bungee-jumping • Circumcision unless necessary for treatment of a disease • Hospitalization where the insured is a donor for any organ transplant • Any treatment outside of Republic of India • Treatment to assist reproduction, including IVF treatment • Hormone Replacement Therapy • Ageing and Puberty • Artificial Life Maintenance • Hereditary Conditions • Sleep disorders • Speech disorders • Treatment for developmental problems

The following are the permanent exclusions under **Critical Illness Cover** (for complete details on the exclusions, please refer to the terms and conditions of the Policy):

• Abuse of drugs or alcohol • Suicide or self-inflicted injuries • HIV and AIDS • Congenital conditions • Hereditary Conditions • Any illness resulting from a physical or mental condition which existed before the effective date of this plan • Failure to seek or follow medical advice • War, invasion, act of foreign enemy, hostilities, armed or unarmed truce, civil war, mutiny, rebellion, revolution, military or usurped power, riots or civil commotion, strikes • Taking part in any naval, military or air force operations during peace time • Participation by insured in any flying activity, except as a bona fide, fare paying passenger of recognized airline • Breach of law with criminal intent • Engaging in or taking part in professional sport(s) or any hazardous pursuits, including but not limited to driving or riding any kind of race; underwater activities involving the use of breathing apparatus or not; martial arts; hunting; mountaineering; parachuting; bungee-jumping • Nuclear contamination

The following are the permanent exclusions under **Personal Accident Cover** (for complete details on the exclusions, please refer to the terms and conditions of the Policy):

• Suicide or self inflicted injury • War, invasion, act of foreign enemy, hostilities, armed or unarmed truce, civil war, mutiny, rebellion, revolution, military or usurped power, riots or civil commotion, strikes • Service in armed forces of any country at war/peace or service in any force of an international body • Taking part in any naval, military or air force operation during peace time • Any breach of law with criminal intent • Taking or absorbing, accidentally or otherwise, any intoxicating liquor, drug, narcotic, medicine, sedative or poison, except as prescribed by a licensed doctor • Inhaling any gas or fumes, accidentally or otherwise, except accidentally in the course of duty • Body or mental infirmity or any disease except where such condition arises directly as a correspondence of an accident during the Policy Period • Participation in aviation other than as a fare-paying passenger in an aircraft that is authorized by the relevant regulation • Engaging in or taking part in professional sport(s) or any hazardous pursuits, including but not limited to driving or riding any kind of race; underwater activities involving the use of breathing apparatus or not; martial arts; hunting; mountaineering; parachuting; bungee-jumping • Any disability arising out of conditions which are pre-existing to the inception of the Policy • Nuclear contamination

7. Family Physician details:

Family Physicians name____

Address____

____

Contact Number _______________________ City _______________________

District _______________ State _______________ Pin Code _______________

8. Existing Insurance Details

Is the Proposer or any of the persons proposed to be insured already insured under or proposed for a health insurance/personal accident Policy with Max Bupa Health Insurance Company Limited or any other insurance company?

(Yes/No)____

If yes, please indicate below the Policy/Application number(s). (Please mention application number in case of pending proposal)

Since when have you been continuously insured D D M M Y Y Y Y

Name	Insurance Company Name	Policy No / Application No.	Insured From (Date)	To (Date)	Sum Insured	Claims details if any

Note: 5% discount to be offered to customers who opt for Health Assurance (complete offering - Critical illness, Personal Accident & Hospital Cash) within 3 months of purchase of Max Bupa's any urban indemnity retail plan. Customers can opt for any Sum Assured under the three covers. **(Please refer the Prospectus and Sales Literature of the Policy for complete details)**

9. Renewal Payment Sign-up

Payment of renewal premium of your Health Assurance Policy can be made every year through continuing your existing ECS instructions with Us. Under this option, your Policy can be renewed promptly, but subject to you completing all additional requirements of information and documentation as may be required by Max Bupa.

Would you like to opt for the ECS renewal option at this stage?

________Yes ________No

If you have chosen 'Yes' above, please fill up the ECS Mandate form as well.

10. Caution

You are obliged to make a full and frank disclosure of all facts material to the assumption of risk in relation to you and every person proposed to be insured that would influence our decision to issue Policy or the terms on which it is issued and you must not misrepresent any information to us. The obligation continues until the Policy is issued and does not end with the submission of this Proposal Form. If therefore, there is any change in the information given herein or new information comes to light before the Policy is issued then you must inform us of the same in writing without delay. If there is insufficient space to provide additional information, whether as requested or otherwise then please attach an extra sheet duly signed. In case of any discrepancy in the information provided, the Policy may be void and claim may get rejected.

11. Authorisation (Please read carefully and put a check mark against each before signing)

☐ I consent to and authorize Max Bupa Health Insurance Company Limited, and /or any of its authorized representatives to seek medical information required for the purpose of policy issuance or claim settlement under this Policy from any hospital/medical practitioner that I or any person proposed to be insured has attended or may attend in future concerning any disease or illness or injury.

☐ I further authorize Max Bupa Health Insurance Company Limited to use and disclose any personal information collected or available with Max Bupa Health Insurance Company Limited (whether contained in this Proposal Form or otherwise obtained) to underwriting companies, claims investigation companies/agencies/service provider and insurance/reinsurance companies for the purpose of processing of this Proposal Form and providing subsequent services with regards to this policy.

☐ I also consent to provide Max Bupa Health Insurance Company Limited, and /or any of its authorized representatives any information and/or document with regard to my occupation, the source of my income and age of the proposed insured, as may be sought by Max Bupa Health Insurance Company Limited for the purpose of policy issuance or claim settlement under this Policy.

12. Authorization for electronic Policy fulfillment and service communications

☐ I hereby consent that the Policy documents may be sent to me by email at ______________________(Please provide us your e-mail id)

☐ I hereby consent to and authorize Max Bupa Health Insurance Company Limited ("Company") to make welcome calls, service calls or any other communication (electronic or otherwise) with respect to the proposed or existing Policy of Company from time to time.

Dated: DD MM YYYY Signature of the Proposer ______________________

Place ______________________ Name of Proposer ______________________

13. Declaration

I hereby declare on my behalf and on behalf of each of the Persons Proposed to be insured that the above information and the statements provided in this Proposal Form are true, complete and correct in all respects and that there is no information which is relevant to this application for insurance that has not been disclosed to Max Bupa Health Insurance Company Limited. I further declare that I am related to each of the Proposed Insured in the manner as stated by me herein and I have insurable interest in each of them. I also hereby declare that the money used by me to pay premium under this proposal has not been derived from any criminal or illegal activity or any unaccounted source. I agree that this proposal and any other information provided and the declaration shall be the basis of the contract between me and all persons to be insured and Max Bupa Health Insurance Company Ltd.

Dated: DD MM YYYY Signature of the Proposer ______________________

Place ______________________ Name of Proposer ______________________

14. Vernacular Declaration

I hereby declare that I have fully explained the contents of the Proposal Form and all other documents incidental to availing the health insurance from Max Bupa Health Insurance Company Limited to the Proposer in the language understood by him/her. The same have been fully understood by him/her and the replies have been recorded as per the information provided by the Proposer and the replies have been read out to fully understood and confirmed by the Proposer.

Declarant's Name:

Relationship with Proposer:

Address:

City Pin Code

Signature of Declarant: ______________________ Signature of Applicant in vernacular: ______________________

Acknowledgment

Proposal Form No. Date DD MM YYYY

We acknowledge with thanks the receipt of your proposal and amount by Cash/Cheque/Demand Draft/ Others______________________ of amount of Rs.______________________dated ______________________drawn on______________________

Neither the submission to Us of a completed proposal for Insurance nor any payment for any Policy sought obliges us to agree to issue a Policy, which decision is and always shall be in out sole and absolute discretion. If we accept a proposal for Insurance, it shall be subject to the Policy terms and conditions and we shall have no liability whatsoever if premium is not received by us in full and in time or is not realized. If we do not accept the proposal, we will inform you and refund the payment, if any, received from you without interest.

Signature of the Receiver and office seal

For Office Use Only

Premium Payment Details: ☐ Cash ☐ Cheque/DD No. ☐ Credit Card

Amount Date DD MM YYYY

Bank Name/Branch

Max Bupa Branch Location Code No.

Business Sourced By: Advisor/DST/Corporate Agency/Other Channels Code No.

Name Code No.

Proposal Received On: Date DD MM YYYY

Processed By ______ Date DD MM YYYY Approved By ______ Date DD MM YYYY

Customer ID

Insurance Advisor's Report

1. Name of the Proposer
2. Are you related to the Proposer? ☐ Yes ☐ No
3. If Yes, nature of relationship?
4. Is this a Proposal Form for yourself? ☐ Yes ☐ No
5. Since when do you know the Proposer? Years Months
6. Are you satisfied with the identity of the Proposer? ☐ Yes ☐ No
7. Does the Proposer or any Proposed Insured have any physical deformity/defect or mental retardation? ☐ Yes ☐ No
8. Have you explained the exclusions of the Policy and has the Proposer personally completed the health declaration? ☐ Yes ☐ No
9. What is the Proposer's state of health at the time of making of this Proposal Form?
10. Do you recommend acceptance of this Proposal Form considering all the factors, including moral hazard? ☐ Yes ☐ No

Date :

Signature of the Insurance Advisor

STATUTORY WARNING AS PER SECTION 41 OF THE INSURANCE ACT 1938
PROHIBITION OF REBATES

Payment of rebates is expressly prohibited under Section 41 of the Insurance Act, 1938.

1. 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 or 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 continuing a Policy accept any rebate except such rebate as may be allowed in accordance with the prospectus or tables of the Insurer.
2. Any person making default in complying with the provisions of this Sections shall be punishable with fine, which may extend to five hundred rupees

Max Bupa
Health Insurance

Max Bupa Health Insurance Company Limited
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Registered Office: Max House, 1, Dr. Jha Marg, Okhla, New Delhi - 110020
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HA/PF/0412/VI