MediPrime

Proposal Form

TATA AIG INSURANCE
WITH YOU ALWAYS

Application No:

This proposal will be the basis of any insurance policy that We may issue. You must disclose all facts relevant to all persons proposed to be insured that may affect Our decision to issue a policy or its price, terms, conditions and exclusions. Non-compliance may result in avoidance of the Policy. If there is insufficient space for You to provide information, whether as requested or otherwise, please attach a separate sheet. If You are in any doubt, please seek advice of Your insurance advisor. We are under no obligation to accept any proposal for insurance. If We accept a proposal for insurance, it shall be subject to the Policy terms and conditions and we shall have no liability to make any payment under the Policy if premium is not received by Us in full and in time, or is not realized. We may apply a risk loading on the premium payable (based upon the declarations made in the proposal form and the health status of the persons proposed for insurance). Please note that We will issue Policy only after getting Your consent in case of risk loading.

Please fill-up this form in CAPITAL LETTERS and attach a passport sized photograph of Yourself and each person proposed to be insured and write the name of the person above the photograph. Please fill the form completely. ^ non mandatory field. ^ ^ any one is mandatory.

1. Personal Detail (Please ☑ in the relevant box wherever necessary)

Proposer (Mr / Mrs. / Ms) First Name | Middle Name | Surname

Address

City / Town | District | State

Pin Code | Tel (Res.) ^ ^ 0 S T D -

Mobile ^ ^ | e-Mail

Nationality : _____ Marital Status : _____ Annual Income : _____

Profession : Salaried ☐ Self Employed ☐ Others ☐ Details : _____

ID Proof Type : PAN ☐ Passport ☐ Driving License ☐ Voter's Card ☐ Any other ID type : _____

ID Proof No.

2. Plan Details

Term : 1 year ☐ 2 year ☐ (Get 5% discount in premium on selecting 2 year term)

Proposed Policy Period : From D D M M Y Y Y Y To D D M M Y Y Y Y

Type : Individual (10% family discount for 3 or more family members) ☐ Family Floater** ☐

Family Floater option : 1 Adult + 1 Child ☐ 1 Adult + 2 Children ☐ 1 Adult + 3 Children ☐

2 Adults ☐ 2 Adults + 1 Child ☐ 2 Adults + 2 Children ☐ 2 Adults + 3 Children ☐

3. Details of the Person(s) proposed to be Insured

Insured	Name of the Insured Person	Ht	Wt	Relationship to Policyholder	Gender	Date of Birth	Occupation	Sum Insured**	Adult (A) / Child (C)***
1.		(cms)	(Kg)		M / F	DD/MM/YY			A ☐ C ☐
2.		(cms)	(Kg)		M / F	DD/MM/YY			A ☐ C ☐
3.		(cms)	(Kg)		M / F	DD/MM/YY			A ☐ C ☐
4.		(cms)	(Kg)		M / F	DD/MM/YY			A ☐ C ☐
5.		(cms)	(Kg)		M / F	DD/MM/YY			A ☐ C ☐
6.		(cms)	(Kg)		M / F	DD/MM/YY			A ☐ C ☐
7.		(cms)	(Kg)		M / F	DD/MM/YY			A ☐ C ☐

a. Maximum entry age is 65 years at completion. b. ** Family Floater policy will have same Sum Insured for all members and maximum no. of Adults can be 2 only; c.*** Dependent children between the age of 91 days to 21 years only will be covered.

4. Photographs of the Person Proposed to be Insured ^

Please paste the photographs in sequence [Insured 1, Insured 2, Insured 3, Insured 4, Insured 5, Insured 6 and Insured 7] as specified in section 3 of details of proposed to be insured.

Insured 1	Insured 2	Insured 3	Insured 4	Insured 5	Insured 6	Insured 7

5. Nominee Details ^

In the event of the death of an Insured Person any payment due under the Policy shall become payable to the nominee in accordance with the Policy terms and conditions. The nominee must be an immediate relative of the Proposer. Nominee for any of the persons proposed to be insured shall be the Proposer.

Nominee Name	Relationship	Address of Nominee

If the Nominee is minor, please give the name and Address of Assignee and relationship with the minor:

Assignee Name	Relationship	Address of Assignee

6. Existing / Previous Insurance Details

Is the proposer or the person(s) proposed, already insured under a plan with Tata AIG General Insurance Company Ltd. or any other insurance company? If yes, please share below the Policy / Application number(s). Please mention application number incase of pending proposal.

Do you want us to consider these details for portability* ? Yes ☐ No ☐

Name of the policy	Previous Policy No.	Insurer	Period of Insurance		Sum Insured (Rs)	Claims lodged during the preceding 3 years	Cumulative Bonus	Membership no. of previous insurer for each insured
			From (DD/MM/YY)	To (DD/MM/YY)				

* Please note that portability shall NOT be considered if the above details are not provided. You need to approach at least 45 days prior to your expiry date to avoid any break in coverage.

7. Medical and Life Style Information

Medical History: Please answer the below mentioned questions individually in Yes (Y) / No (N). Please ☑ in the relevant box

Section A : Have any of the person proposed to be insured ever suffered from / are currently suffering from any of the following :		Insured 1		Insured 2		Insured 3		Insured 4		Insured 5		Insured 6		Insured 7	
		Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N
I.	Hypertension, Chest Pain, Ischemic heart disease or any other cardiac disorder														
ii.	Tuberculosis, Asthma, Bronchitis or any other lung / respiratory disorder														
iii.	Ulcer (Stomach / Duodenal), Hepatitis, Cirrhosis or any other digestive or liver / gallbladder disorder														
iv.	Renal Failure, Calculus or any other kidney / urinary tract or prostate disorder														
v.	Dizziness, Stroke, Epilepsy, Paralysis or other brain / nervous system disorder														
vi.	Diabetes, Thyroid Disorder or any other endocrine disorder														
vii.	Tumor-benign or malignant, any ulcer / growth / cyst														
viii.	Arthritis, Spondylosis or any other disorder of the muscle / bone / joint														
ix.	Diseases of the Nose / Ear / Throat / Teeth / Eye (please mention Dioptres)														
x.	HIV / AIDS or sexually transmitted diseases or any immune system disorder														
xi.	Anaemia, Leukaemia or any other blood / lymphatic system disorder														
xii.	Psychiatric / Mental illnesses or sleep disorder														
xiii.	DUB, Fibroid, Cyst / Fibroadenoma or any other Gynaecological / Breast disorder														

Section B : Have any of the person proposed to be insured :		Insured 1		Insured 2		Insured 3		Insured 4		Insured 5		Insured 6		Insured 7	
		Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N
xiv.	Been addicted to alcohol, narcotics, habit forming drugs or been under detoxication therapy?														
xv.	Been under any regular medication (self / prescribed)?														
xvi.	Undertaken any lab / blood tests, imaging tests viz. scans / MRI in the last 5 years other than routine health check-up or pre-employment check-up?														
xvii.	Undertaken any surgery or a surgery been advised in the last 10 years or have surgery still pending?														
xviii.	Suffered from any other disease / illness / accident / injury other than common cold or viral fever?														
xix.	Is any of the insured pregnant? If yes please mention the expected date of delivery														
xx.	Any complaint of Diabetes, Hypertension or any complication during current or earlier pregnancy?														

Section C : Have you or any person proposed to be insured received any advice / treatment / consultation for any medical condition in the last 3 years?	Y	N

Section D : If yes, for the questions in the Section 7 A, 7 B & 7 C above, please specify details of Treatment, Institution and Doctor (Identify per family member)

Insured Name	Name of Pre-Existing Diseases / Illness / Surgery	Diagnosis Date	Date of last consultation	Treatment Inpatient / Outpatient	Doctor(s) Name	Hospital(s) Name	Hospital(s) Phone No. with STD code
		DD/MM/YYYY	DD/MM/YYYY				
		DD/MM/YYYY	DD/MM/YYYY				
		DD/MM/YYYY	DD/MM/YYYY				
		DD/MM/YYYY	DD/MM/YYYY				
		DD/MM/YYYY	DD/MM/YYYY				
		DD/MM/YYYY	DD/MM/YYYY				
		DD/MM/YYYY	DD/MM/YYYY				

Section E : Name, address, qualification and contact details of the family doctor, if any

Name

Address

Qualification Tel. 0 S T D -

Mobile e-Mail

Section F : Does any person proposed to be Insured smoke or consume gutkha / pan masala or alcohol? If yes, please indicate the name and quantity per week.	Alcohol	Smoke	Pan Masala	Others
Insured 1				
Insured 2				
Insured 3				
Insured 4				
Insured 5				
Insured 6				
Insured 7				

Section G : Please ☑ in the relevant box In respect of any of the persons proposed to be insured :	Insured 1		Insured 2		Insured 3		Insured 4		Insured 5		Insured 6		Insured 7	
	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N
Has any application for life, health, hospital daily cash, critical illness or cancer insurance ever been declined, postponed, loaded or been made subject to any special conditions by any insurance company?														

8. Payment Details

Name of the Premium Payer

Amount (in Rs.)

Please make a Crossed Cheque / DD / Pay Order in favour of 'Tata AIG General Insurance Company Limited' only.

Instrument type Cash ☐ Cheque ☐ Debit Card ☐ Credit Card ☐ Others :_____

Cheque / DD No. Date D D M M Y Y Y Y

Bank Name Branch

Credit / Debit Card No. Expiry Date D D M M Y Y Y Y

Sources of funds : (Please tick where applicable) Salary ☐ Business ☐ Other : _____

I. Section 41 of Insurance Act 1938 (Prohibition of Rebates) :

a. No person shall allow or offer to allow, either directly or indirectly, as an inducement to any person to take 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 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 prospectus or tables of the insurers.

b. Any person making default in complying with the provision of this section shall be punishable with fine which may extend to five hundred rupees.

II. AML guidelines :

a. I / we hereby confirm that all premiums have been / will be paid from bonafide sources and no premiums have been/will be paid out of proceeds of crime related to any of the offence listed in prevention of Money Laundering Act, 2002.

b. I understand that the Company has the right to call for documents to establish sources of funds.

c. The insurance company has right to cancel the insurance contract in case I am / have been found guilty by any competent court of law under any of the statutes, directly or indirectly governing the prevention of money laundering in India.

Any Additional Information
(If there is insufficient space to provide additional relevant information, whether as requested or otherwise, please attach extra sheet duly signed.)

III. General Exclusions (Under the Policy) For more details please refer to the Policy Wordings

The following is an outline of the general exclusions under the policy. For more details on the exclusions and the waiting periods please refer to the policy wordings before purchasing this policy.

30 days waiting period in the first year and is not applicable in subsequent renewals, War or any act of war, invasion, act of foreign enemy, war like operations, nuclear weapons/materials radiation of any kind, committing or attempting to commit a breach of law with criminal intent, or intentional self injury or attempted suicide while sane or insane, participation or involvement in naval, military or air force operation or any hazardous or dangerous or adventurous activities including but not limited to racing, driving, aviation, scuba diving, parachuting, hang-gliding, rock or mountain climbing, abuse or the consequences of the abuse of intoxicants or hallucinogenic substances such as intoxicating drugs and alcohol, smoking cessation programs and the treatment of nicotine addiction or any other substance abuse treatment or services or supplies, treatment of obesity or any weight control program, psychiatric, mental disorders, Parkinson and Alzheimer's disease, general debility or exhaustion ("run-down condition"), congenital internal or external diseases, genetic disorders, stem cell implantation or surgery or growth hormone therapy, sleep apnoea, venereal disease, sexually transmitted disease, "AIDS" (Acquired Immune Deficiency

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Syndrome) and/or infection with HIV (Human immunodeficiency virus), sterility / infertility treatment of any type, pregnancy (including voluntary termination), miscarriage (except as a result of an Accident or Illness) except in the case of ectopic pregnancy, treatment and supplies for analysis and adjustments of spinal subluxation, diagnosis and treatment by manipulation of the skeletal structure, muscle stimulation by any means except for treatment of fractures (excluding hairline fractures) and dislocations of the mandible and extremities, dental treatment unless requiring hospitalization, treatment of nasal concha resection, circumcisions unless necessitated by illness or injury and forming part of treatment, laser treatment for correction of eye due to refractive error, aesthetic or change-of-life treatments, plastic surgery or cosmetic surgery unless necessary as a part of medically necessary treatment for reconstruction following an Accident, Cancer or Burns, experimental, investigational or unproven treatment devices and pharmacological regimens, measures primarily for diagnostic, X-ray or laboratory examinations or other diagnostic studies which are not consistent with or incidental to the diagnosis and treatment, convalescence, cure, rest cure, sanatorium treatment, rehabilitation measures, private duty nursing, respite care, long-term nursing care or custodial care, all preventive care, vaccination including inoculation and immunizations (except in case of post- bite treatment), any non allopathic treatment, enteral feedings and other nutritional and electrolyte supplements, unless certified to be required by the attending Medical Practitioner as a direct consequence of an otherwise covered claim, charges related to a Hospital stay not expressively mentioned as being covered, items of personal comfort and convenience, vitamins and tonics, treatments rendered by a Medical Practitioner which is outside his discipline or the discipline for which he is licensed, treatments rendered by a Medical Practitioner who shares the same residence as an Insured Person or who is a member of an Insured Person's family, costs of any procedure or treatment by any person or institution that we have told you (in writing) is not to be used, the provision or fitting of hearing aids, spectacles or contact lenses including optometric therapy, any treatment and associated expenses for alopecia, baldness, wigs, or toupees, medical supplies including elastic stockings, diabetic test strips, and similar products, any treatment or part of treatment that is not of a reasonable cost, not medically necessary; drugs or treatment which are not supported by a prescription, artificial limbs, crutches or any other external appliance and/or device used for diagnosis or treatment.

IV. Coinsurance option (Please ☑ in the relevant box)

- ☐ I agree to exercise Coinsurance option with Tata AIG General Insurance Company Ltd. (Lead insurer) and Apollo Munich Health Insurance Company Ltd (Co-Insurer).
- ☐ I do not require a Coinsurance option
- ☐ I agree to exercise Coinsurance option with Tata AIG General Insurance Company Ltd. (Lead insurer) and _____ (Co-Insurer).

Notwithstanding the role and liability of the co-insurer in terms of the above co-insurance arrangement, for the avoidance of doubt, it is hereby declared that the Lead Insurer is the Insurer for all Policy purposes including but not limited to the collection of premium, policy administration, notices, claims decisions, and the payment of claims.

V. Declaration & warranty on behalf of all persons proposed to be insured (Please ☑ all boxes)

- ☐ I hereby declare and warrant on my behalf and on behalf of all persons proposed to be insured that the above statements are true and complete in all respects. I agree that this proposal and the declarations shall be the basis of the contract between me and all persons to be insured and Tata AIG General Insurance Company Ltd.
- ☐ I further consent and authorize Tata AIG General Insurance Company Ltd. and/or any of their authorized representatives to seek medical information from any hospital / consultant / insurer that I or any person proposed to be insured has attended or may attend in future concerning any disease or illness or injury in respect to a particular claim.
- ☐ I agree to Tata AIG General Insurance Company Limited taking appropriate measures to capture the voice log for all such telephonic transactions carried out by me, in accordance with procedures / regulations.

Date D D M M Y Y Y Y Signature of the Proposer : _____

Place : _____

VI. Vernacular declaration

Certification in case the proposer has signed in vernacular (to be witnessed by someone other than agent / employee of the company):

Name of Proposer _____ (First Name) _____ (Middle Name) _____ (Surname)

The content of this form and its particulars have been explained by me in vernacular to the proposer who has understood and confirmed the same.

Signature of Proposer : _____ Signature of the witness : _____

☒ Date D D M M Y Y Y Y Name of the witness : _____

Place : _____

VII. Agent's Declaration

I, _____ (Full Name) in my capacity as an Insurance Advisor / Specified Person of the Corporate Agent / Authorised employee of the Broker / Relationship Officer, do hereby declare that I have explained all the contents of this Proposal Form, including the nature of the questions contained in this Proposal Form to the Proposer including statement(s), information and response(s) submitted by him/her in this Proposal Form to questions contained herein or any details sought herein will form the basis of the Contract of Insurance between the Company and the Proposer, if this Proposal is accepted by the Company for issuance of the Policy. I have further explained that if any untrue statement(s) / information / response(s) is / are contained in this Proposal Form / including addendum(s), affidavits, statements, submissions, furnished / to be furnished, the Company shall have the right to vary the benefits which may be payable and further more if there has been a non-disclosure of any material fact, the policy issued to his / her favour pursuant to this Proposal may be treated by the Company as null and void and all premiums paid under the Policy may be forfeited to the company.

License No. (Advisor / Corporate Agent / Broker / Relationship Officer _____

Place : _____

Date D D M M Y Y Y Y Signature of Agent : _____

VIII. For office use only

Tata AIG Office : _____ Producer code and Name : _____

Branch receipt No. : _____ Branch receipt date : _____

Business Type : ☐ Urban ☐ Rural ☐ Social

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Acknowledgement

Application No.: _____

Name of Proposer : _____

We acknowledge with thanks the receipt of your application and amount by cash / cheque / demand draft / others _____

of amount Rs. _____

Place: _____ Signature and Seal : _____

Date D D M M Y Y Y Y

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 our 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 to make any payment if premium is not received by us in full and in time, or is not realised or non-fulfillment of Pre Policy Check-up. If we do not accept the proposal, we will inform you and refund any payment received from you without interest within next 30 days.

Tata AIG General Insurance Company Limited

Insurance is the subject matter of the solicitation. For more details on risk factors, terms and conditions, please read sales brochure carefully, before concluding a sale. Tata AIG General Insurance Company Ltd. Registered office: Peninsula Corporate Park, Piramal Tower, 9th Floor, G.K. Marg, Lower Parel, Mumbai - 400013. Toll Free No. 1800 266 7780