

Empower Health Plan, Niva Bupa Health Insurance Co. Ltd. - Proposal Form

URN: 027

Insurance contract is a legal contract too and it's based on TRUST and We TRUST You. We understand you may not know how relevant is the information our health and its impact on your policy. Hence, it is very important that you disclose all health information and we would decide how relevant it is (we call it 'material fact'). We would cancel your policy, will not pay any claim, will not refund any premium paid and have right to take all possible legal actions against you including for recovery of benefits paid earlier, if correct and complete information is not provided about all members proposed to be insured. Regulations mandate that the coverage can start only after we have received the full premium and have explicitly accepted the risk.

1. Proposer details: Title Name		Date of Birth	Gender: □Male□Female□ Other
Current address			
City			
State	Pin code	_	
Mobile number	1 III code		
Email ID	PAN Number	(Mandatory for premium ab	pove Rupees 50,000 in cash and Rupees 1 lac through other modes)
Nationality	Annual income (Rs)		
			pecify
Health Care Worker*: ☐ Yes ☐ N	lo		
* Avail a discount of 5% on the p	remium.		
Premium paid by		Relations	hip with Proposer
☐ I wish to receive my policy rela	ted information and undat	es over WhatsAnn on my	mohile number
	·		e Niva Bupa Health Insurance or any of its Agents and/or th
			any other modes on my registered phone number over-ridi
my 'DND' registration to make			
, 0		•	
Are you or any of the proposed a	applicants a PEP**? Tyes	No	
	• •		t public functions i.e. Heads / ministers of central or state governme
		•	nent companies, important party officials. (If you have ticked agai
PEP, kindly fill the separate PEP ques	tionnaire)		
Bank details:			
	Branch	Citv	
Account number II	SC Code	Accour	nt type: Savings Current
			7,Fer = earringe = earrierin
Details of Electronic Insurance A	•		
Do you wish to have this Policy c			ny one)
No □ I do not have an e-insura		sh to open one	
Yes Credit this Policy to my e			
If yes, Please share existing E-Ins	urance Account No.□		
Diagon solo et la companya Domosito			
Please select Insurance Reposito			Dan asita and Lineita d 🗆
M/s NSDL Database Manag			
			Services Limited \square (Please select any one) Or
I do not have existing e-Insuranc		•	
(Please submit electronic insurar	nce account opening form	(eIA form) along with rele	vant documents).
2. Coverage selection:			
Base coverage:			
Policy type:			□Individual
Base Sum Insured:			☐ INR 4,00,000 ☐ INR 5,00,000
Policy term:			1 Year
-,			

3	. Details o	f applicants	for insurance:

Applicant	Name	Gender	Date of birth	Relationship	Please tick if
Number		(Male/Female/Other)	(dd/mm/yyyy)		not Indian
1				Self	

4. Nomination

In the event of the death of the Proposer, any payment due under the Policy shall become payable to the Nominee named below. The receipt of such payment by the Nominee would constitute discharge of the Company's liability under the Policy. Nominee for all other applicant(s) shall be the proposer himself/herself.

Nominee	Date of	Relationship with the	Address and contact details of	Appointee Name (if nominee is less than 18
Name	Birth	Proposer	Nominee	years of age)

5. Medical, habits and past proposal information

IMPORTANT: Please ensure that all the questions in this section are answered truthfully and completely as the information You provide here will form basis of underwriting by Niva Bupa. Please note any incomplete, incorrect, partially correct information may affect your medical claim and/or coverage.

	Please answer the following questions for the Main Applicant		Applicant	
	Please circle Yes (Y) or No (N)			
1	Has any applicant been diagnosed with any of the following disabilities/diseases (if yes, please provide details)			
a.	Blindness	Υ	N	
b.	Muscular Dystrophy	Υ	N	
C.	Low Vision	Υ	N	
d.	chronic neurological disorder	Υ	N	
e.	Leprosy cured person	Υ	N	
f.	Specific Learning disabilities	Υ	N	
g.	Hearing impairment (deaf and hard of hearing)	Υ	N	
h.	Multiple sclerosis	Υ	N	
i.	Locomotor Disability	Υ	N	
j.	Speech and language disability	Υ	N	
k.	Dawrfism	Υ	N	
l.	Thalassemia	Υ	N	
m.	Intellectual Disability	Υ	N	
n.	Haemophilia	Υ	N	
0.	Mental Illness	Υ	N	
p.	Sickle Cell Disease	Υ	N	
q.	Autism Spectrum Disorder	Υ	N	
r.	Multiple Disability Including deaf and blindness	Υ	N	
s.	Cerebral Palsy	Υ	N	
t.	Acid Attack Victim	Υ	N	
u.	Parkinson	Υ	N	
2	Other than common cold, flu, infections, minor injury or other minor ailments; has the Applicant ever been diagnosed with any disease and / or hospitalized for more than 5 days and / or undergone / advised to undergo any surgical procedures and / or taken any medication/ had any symptoms for more than 14 days? Medication is including but not limited to inhalers, injections, oral drugs and external medical applications on body parts.	Υ	N	
3	Has the Applicant ever had adverse findings to any diagnostic tests or investigations related to Thyroid Profile, Lipid Profile, Treadmill test, Angiography, Echocardiography, Endoscopy, Ultrasound, CT Scan, MRI, Biopsy and FNAC?	Υ	N	
4	Does the Applicant have diabetes or pre-diabetes or has he/she EVER had high blood sugar?	Υ	N	
5	Does the Applicant have Hypertension or High Blood Pressure?	Υ	N	

	6	Has the Applicant ever been diagnosed or treated for any genetic / hereditary disorders or HIV / AIDS?	Υ	N		
	7	Has any proposal for life, health, hospital daily cash or critical illness insurance on the life of the Applicant ever been declined, postponed, loaded or subjected to any special conditions such as exclusions by any insurance company?	Υ	N		
		conditions and characters by any mean and company.				
6.	Λιι+h	orization for electronic Policy fulfillment and service communications				
0.		d you like to protect the environment and help save paper by authorizing the Company to send	all your Policy and	service related		
		nunication to the email ID as mentioned here in the application form? Yes No	,			
_	Daal					
7.		aration (Please read carefully and put a check mark against each before signing the proposal form) ereby declare, on my behalf and on behalf of all persons proposed to be insured, that the above state	ements, answers an	d/or particulars		
		by me are true and complete in all respects to the best of my knowledge and that I am authorized t				
	perso	ns. Iderstand that the information provided by me will form the basis of the insurance Policy, is subject to	n the Board approve	ed underwriting		
	Policy	of the insurer and that the Policy will come into force only after full payment of the premium charg	eable.			
		rther declare that I will notify in writing any change occurring in the occupation or general health of the opposal has been submitted but before communication of the risk acceptance by the company.	he life to be insured	/proposer after		
	I de	eclare that I consent to the company seeking medical information from any doctor or hospital who/				
		erson to be insured/proposer or from any past or present employer concerning anything which affec erson to be insured/proposer and seeking information from any insurer to whom an application for ins				
	/prop	oser has been made for the purpose of underwriting the proposal and/or claim settlement.				
		ithorize the company to share information pertaining to my proposal including the medical records on The see of underwriting the proposal and/or claims settlement and with any Governmental and/or Regul		ser for the sole		
	Dated	I//_ Place Signature of the Proposer				
8.	Vern	acular declaration				
	(Certification in case the Proposer has signed in vernacular (to be witnessed by someone other than agent/ employee of the Company)). 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: Name of the certifying person: Signature of the certifying person: Mobile number of the certifying person: Signature of the Witness: Signature of the Proposer Signature of the Witness: Signature of the Witness: Signature of the Proposer Signature of the Witness: Signature					
9.	Prop	oser declaration				
	(Certification where for any reason, the proposal and other connected papers are not filled in by the Proposer). The contents of the proposal form and connected documents have been fully explained to me and I have fully understood the significance of the proposed contract. The Proposal Form is filled by under my instruction and I found it to be correct.					
	Signature of the Proposer					
10	Drow	ium details (for office use only)				
10.	FIEII	indiri details (for office use offiy)				
	Onlin Niva I Code	tum payment option Cheque Demand Draft Credit card Cash Other Premium amount Payment transaction ID: Date: Date:	e agency/ other cha	nnels		
11.	Addi	tional details for Bancassurance channel only (for office use only)				
		h Code SP Code RM/LG code mer account number				
	- 3000	ance advisor's report (for office use only)				

I, 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 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.

Date __/_ _/ ___ Signature of the Insurance Advisor_____

(Note – The details provided under Section 10, 11 and 12 are for office use only and are not to be filled by the Proposer. Therefore, these sections are indicative as they do not have any relation with the details filled by Proposer. This note won't appear in the proposal form sent to the customers and is a part of file & use approval only)

13. Statutory Warning

Prohibition of Rebates (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 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.
- 2. Any person making default in complying with the provisions of this section shall be liable for a penalty which may extend to ten lakh rupees.

Niva Bupa Health Insurance Company Limited; Registered office:- C-98, First Floor, Lajpat Nagar, Part 1, New Delhi-110024
Disclaimer: Insurance is a subject matter of solicitation. Niva Bupa Health Insurance Company Limited (formerly known as Max Bupa Health Insurance Company Limited) (IRDAI Registration No. 145). (Bupa' and 'HEARTBEAT' logo are registered trademarks of their respective owners and are being used by Niva Bupa Health Insurance Company Limited under license. Customer Helpline: 1860-500-8888. Website: www.nivabupa.com. CIN: U66000DL2008PLC182918. For more details on terms and conditions, exclusions, risk factors, waiting period & benefits, please read sales brochure carefully before concluding a sale.

Product Name: Empower Health Plan, Niva Bupa Health Insurance Pvt. Ltd. | UIN: NBHHLIP23193V012223

Acknowledgment by the Company

Application No.	Date//
We acknowledge with thanks the receipt of your proposal and amount by Cheque/Demand Draft/ Others	of amount of
Rsdateddrawn on	

Neither the submission to us of a completed proposal for Insurance nor any payment made towards issuance of a Policy 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's 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 after deducting cost of medical tests, if any, received from you without interest.

Name and Signature of the receiver and office seal $% \left(1\right) =\left(1\right) \left(1\right) \left($