Oocyte Guard – Proposal Form

URN: 028



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 on your health and its impact on your policy. Hence, it's 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 action 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. Pro	oposer detail	s:																										
Proposer: ((Mr/Mrs/Ms)																											Π
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	Hediti insurance												
								name and address					
								of workplace*					
1		(M / F											
		/Other)											

Base coverage:								
Policy type#:	Individual							
Number of lives to be covered:	1							
Base Sum Insured:								
Policy term:	1 Year							

3. Portability

Policy No	Insurance company	Risk date	start	Risk date	end	Reasons for Porting

Name of proposed insured for whom portability is requested	First policy start date	No of years of continuous coverage for which portability is	Claims in past policies	Current No claim Bonus	Sum insured – Year 1 (Oldest)	Sum insured- Year 2	Sum insured – Year 3	Sum insured – Year 4 (Expiring
requesteu		requested			(Oldest)			policy)

4. Nomination

In the event of the death of the Proposer, claim shall be paid to the Nominee. For other insured persons, Proposer is the nominee. Payment to the nominee constitutes discharge of the Company's full liability.

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.

Section A		
Please answer the following questions for each applicant.		
Please circle Yes (Y) or No (N)	1	
i. 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

		niva
ii. 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?	Y	Health Insurance N
iii. Does the Applicant have diabetes or pre-diabetes or has he/she EVER had high blood sugar?	Υ	N
iv. Does the Applicant have Hypertension or High Blood Pressure?	Υ	N
v. Has the Applicant ever been diagnosed or treated for any genetic / hereditary disorders or HIV / AIDS?	Υ	N
vi. Has the Applicant ever been diagnosed or treated for any mental/ psychiatric disorders?	Υ	N
vii. Has the Applicant ever been diagnosed with any gynecological disease for which any intervention, hormonal replacement therapy or medication exceeding 5 days have been prescribed?	Y	N
viii. If the Applicant has ever been pregnant then have there been any complication in pregnancy?	Υ	N
ix. Has the Applicant ever had any abnormal vaginal bleeding or irregularities in menstruation?	Υ	N

Section B: I	For questions	marked Yes (Y)	in Section	Above, p	lease spe	cify follow	ing info	ormation:		
Applicant Number		ymptom(s) or ir ir procedure / si	_		Durati on of condit ion	Medica tion(s)	Dos age	Current status (e.g. Complete / partial recovery or ongoing treatment)	Treating doctor's name & contact details	Documen ts attached (Yes / No)
	If Diabetes HbA1c Level	If High blood pressure BP Level Systolic / Diastolic	Any Other Details	Onset date (DD/ MM/ YYYY)						

6. I	Declaration ((Please read carefu	lly and	put a check mark a	gainst each befo	re signing	the proposal	form)
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I hereby declare, on my behalf and on behalf of all persons proposed to be insured, that the above statements, answers and/or particulars given by me are true and complete in all respects to the best of my knowledge and that I am authorized to propose on behalf of these other persons. I understand that the information provided by me will form the basis of the insurance Policy, is subject to the Board approved underwriting Policy of the insurer and that the Policy will come into force only after full payment of the premium chargeable. I further declare that I will notify in writing any change occurring in the occupation or general health of the life to be insured/proposer after the proposal has been submitted but before communication of the risk acceptance by the company. I declare that I consent to the company seeking medical information from any doctor or hospital who/which at any time has attended on the person to be insured/proposer or from any past or present employer concerning anything which affects the physical or mental health of
the person to be insured/proposer or from any past or present employer concerning anything which affects the physical or mental health of the person to be insured/proposer and seeking information from any insurer to whom an application for insurance on the person to be insured
/proposer has been made for the purpose of underwriting the proposal and/or claim settlement. I authorize the company to share information pertaining to my proposal including the medical records of the insured/proposer for the sole
purpose of underwriting the proposal and/or claims settlement and with any Governmental and/or Regulatory authority.
if the Proposer has signed in vernacular: The content of this form have been explained by me, Name of the person certifying in in presence of Name of witness to the Proposer who has understood and confirmed the same. Witness must be someone other than agent/ employee of the Company.
Dated// Place Signature of the Proposer
Signature of the certifying Person Mobile number of the certifying Person

Signature of the Witness	Mobile number of the	



Declaration if form is NOT filled by the proposer & Advisor declaration
Declaration if for any reason, the proposal and other connected papers are not filled by the Proposer. The contents of the proposal form have been fully explained to me and I have fully understood all aspects and implications. The Proposal Form is filled by
Signature of the Proposer
Advisor declaration: I 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 product / proposal to the Proposer Signature of the Insurance Advisor Intermediary code:
Premium details (for office use only)
Premium payment option Cheque Demand Draft Credit card Debit card Net Banking Cash Others Premium amount Premium paid by Relationship with proposer Online payment transaction ID: Date:// Bank name/ branch Niva Bupa branch location Code No Business sourced by: Advisor/DST/Corporate agency/ other channels Code No Name Proposal received on: Customer ID: Is Proposer or the applicant a staff? Yes No
NEFT & Bank details
All payments (refund of premium, claims etc) would be made electronically ONLY to your account. Please provide following details
Bank name Branch City Account number IFSC Code Account type: Account type: Savings Current

10. Renewal

7.

8.

9.

Renewal payment sign-up:

Payment of renewal premium of your health insurance Policy can be made every year through continuing your existing Automated Clearing House (ACH) / Standing Instructions (SI) with the Company. 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 the Company.

___ I want to opt for the ACH/SI renewal option and thereby avail a discount of 2.5% on the premium till the time policy is renewed using the same.

Dated _ /_ /_ _ Place ____ Signature of the Proposer _____

11. Additional details for Bancassurance channel only (for office use only)

Branch Code _____ SP Code ____ RM/LG code _____
Customer account number _____

12. Statutory Warning

Prohibition of Rebates (Under Section 41 of the 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.
- 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.

13. 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
Rsdateddated	

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

14.	Insurance Advisor's Report (for office use only)
1.	Are you related to the Proposer? Yes/No; If yes, nature of relationship?
2.	For how long have you known the Proposer? Years Month
3.	Are you satisfied with the identity of the Proposer? YesNo
4.	Does the Proposer or any applicant have any physical deformity/defect or mental retardation? YesNo
5.	Have you explained the exclusions of the policy and has the Proposer personally completed the health declaration?
	YesNo
6.	What is the Proposer's state of health at the time of making of this proposal form?
7.	Do you recommend acceptance of this proposal form considering all the factors including moral hazard? Yes
	No
8.	Have you dispassionately advised the Proposer and provided all material information to enable the Proposer to
	decide in the best cover that would be in his / her interest? YesNo
Dat	te Signature of Insurance Advisor