

ReAssure 3.0 Proposal Form

URN: 032

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 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 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. Proposer Details:

Title	Name	
DOB	Gender: Male Female Other	Nationality
Current address		
Landmark		
District	State	City
Landline number	Mobile number	Pincode
Email ID	Alternate number	
PAN Number		
Annual income (Rs)	CKYC Number	
Occupation	Salaried Self-employed Student Housewife Other, please specify	
Premium paid by	Relationship with Proposer	

☐ I would like to protect the environment and help save paper by authorizing the Company to send all your Policy and service related communication to the email ID as mentioned here in the application form?

☐ I have read, understood and accepted all Terms and Conditions & hereby authorize Niva Bupa Health Insurance or any of its Agents and/or third party(ies) / affiliates to contact me via SMS / Email / Phone / WhatsApp / Facebook or any other modes on my registered phone number over-riding my 'DND' registration to make welcome calls / SMS, service calls / SMS or any other commercial communication.

Do you want the Physical Copy of the Policy Kit ☐ Yes ☐ No

Are you or any of the proposed applicants a PEP? ☐ Yes ☐ No

#Politically Exposed Persons (PEP) are individuals who are or have been entrusted with prominent public functions i.e. Heads / ministers of central or state government, senior politicians, senior government, judicial or military officials, senior executives of government companies, important party officials. (If you have ticked against PEP, kindly fill the separate PEP questionnaire)

Bank details:

Bank name		
Account number	IFSC Code	
Account type	Savings Current Branch	City

Details of Electronic Insurance Account (eIA)

Do you wish to have this Policy credited to an eIA? (Please select any one)

☐ No, I do not have an eIA and do not wish to open one ☐ Yes, Credit this Policy to my e-Insurance account

If yes, Please share existing e-Insurance Account No.

Please select Insurance Repository Name (you have opened your account with)

<input type="checkbox"/> M/s NSDL Database Management Limited	<input type="checkbox"/> M/s Central Insurance Repository Limited
<input type="checkbox"/> M/s Karvy Insurance Repository Limited	<input type="checkbox"/> M/s CAMS Repository Services Limited (Please select any one) Or

☐ I do not have existing e-Insurance account and I am interested in creating a new e-Insurance account
(Please submit electronic insurance account opening form (eIA form) along with relevant documents).

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.

Date	Place	Signature of the Proposer
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2. Details of applicants for insurance:

Applicant 1	Name										
	Gender	<input type="checkbox"/> Male	<input type="checkbox"/> Female	<input type="checkbox"/> Other	Height	<input type="text"/> (ft)	<input type="text"/> (inch)	Weight	<input type="text"/> (kg)		
	Mobile number	<input type="text"/>			Date of Birth	<input type="text"/>			Please tick if not Indian	<input type="checkbox"/>	
	Relationship to Proposer (Please tick option): Self / Spouse / Father / Mother / Father-in-law / Mother-in-law / Son / Daughter / Employee										
	If a registered Medical Practitioner*, please provide: i. Medical Registration Number <input type="text"/>										
	ii. Council Name <input type="text"/>										
iii. Address of workplace <input type="text"/>											
Applicant 2	Name										
	Gender	<input type="checkbox"/> Male	<input type="checkbox"/> Female	<input type="checkbox"/> Other	Height	<input type="text"/> (ft)	<input type="text"/> (inch)	Weight	<input type="text"/> (kg)		
	Mobile number	<input type="text"/>			Date of Birth	<input type="text"/>			Please tick if not Indian	<input type="checkbox"/>	
	Relationship to Proposer (Please tick option): Spouse / Father / Mother / Father-in-law / Mother-in-law / Son / Daughter										
	If a registered Medical Practitioner*, please provide: i. Medical Registration Number <input type="text"/>										
	ii. Council Name <input type="text"/>										
iii. Address of workplace <input type="text"/>											
Applicant 3	Name										
	Gender	<input type="checkbox"/> Male	<input type="checkbox"/> Female	<input type="checkbox"/> Other	Height	<input type="text"/> (ft)	<input type="text"/> (inch)	Weight	<input type="text"/> (kg)		
	Mobile number	<input type="text"/>			Date of Birth	<input type="text"/>			Please tick if not Indian	<input type="checkbox"/>	
	Relationship to Proposer (Please tick option): Spouse / Father / Mother / Father-in-law / Mother-in-law / Son / Daughter										
	If a registered Medical Practitioner*, please provide: i. Medical Registration Number <input type="text"/>										
	ii. Council Name <input type="text"/>										
iii. Address of workplace <input type="text"/>											
Applicant 4	Name										
	Gender	<input type="checkbox"/> Male	<input type="checkbox"/> Female	<input type="checkbox"/> Other	Height	<input type="text"/> (ft)	<input type="text"/> (inch)	Weight	<input type="text"/> (kg)		
	Mobile number	<input type="text"/>			Date of Birth	<input type="text"/>			Please tick if not Indian	<input type="checkbox"/>	
	Relationship to Proposer (Please tick option): Spouse / Father / Mother / Father-in-law / Mother-in-law / Son / Daughter										
	If a registered Medical Practitioner*, please provide: i. Medical Registration Number <input type="text"/>										
	ii. Council Name <input type="text"/>										
iii. Address of workplace <input type="text"/>											
Applicant 5	Name										
	Gender	<input type="checkbox"/> Male	<input type="checkbox"/> Female	<input type="checkbox"/> Other	Height	<input type="text"/> (ft)	<input type="text"/> (inch)	Weight	<input type="text"/> (kg)		
	Mobile number	<input type="text"/>			Date of Birth	<input type="text"/>			Please tick if not Indian	<input type="checkbox"/>	
	Relationship to Proposer (Please tick option): Spouse / Father / Mother / Father-in-law / Mother-in-law / Son / Daughter										
	If a registered Medical Practitioner*, please provide: i. Medical Registration Number <input type="text"/>										
	ii. Council Name <input type="text"/>										
iii. Address of workplace <input type="text"/>											
Applicant 6	Name										
	Gender	<input type="checkbox"/> Male	<input type="checkbox"/> Female	<input type="checkbox"/> Other	Height	<input type="text"/> (ft)	<input type="text"/> (inch)	Weight	<input type="text"/> (kg)		
	Mobile number	<input type="text"/>			Date of Birth	<input type="text"/>			Please tick if not Indian	<input type="checkbox"/>	
	Relationship to Proposer (Please tick option): Spouse / Father / Mother / Father-in-law / Mother-in-law / Son / Daughter										
	If a registered Medical Practitioner*, please provide: i. Medical Registration Number <input type="text"/>										
	ii. Council Name <input type="text"/>										
iii. Address of workplace <input type="text"/>											

* Avail a discount of 5% on the premium. Medical Practitioner means a person who holds a valid registration from the Medical Council of any State or Medical Council of India or Council for Indian Medicine or for Homeopathy set up by the Government of India or a State Government and is thereby entitled to practice medicine within its jurisdiction; and is acting within the scope and jurisdiction of his license.

Notes: 1. If the relationship of Applicant 1 with Proposer is employee, then the relationship of other Applicants are with Applicant 1.

3. Coverage Selection

Base Coverage

Policy Type [#]	<input type="checkbox"/> Individual	<input type="checkbox"/> Family Floater	<input type="checkbox"/> Multi-Member Individual
Number of Lives to be Covered	<input type="checkbox"/> Adults	<input type="checkbox"/> Children	
Variant	<input type="checkbox"/> Classic	<input type="checkbox"/> Select	<input type="checkbox"/> Elite <input type="checkbox"/> Black
Base Sum Insured	<input type="checkbox"/> Unlimited	<input type="checkbox"/> ₹ 5,00,000	<input type="checkbox"/> ₹ 10,00,000
Policy Term	<input type="checkbox"/> 1 Year	<input type="checkbox"/> 2 Year	<input type="checkbox"/> 3 Year <input type="checkbox"/> 4 Year <input type="checkbox"/> 5 Year

Optional Coverage

1. Cash-Bag+	<input type="checkbox"/> Yes	<input type="checkbox"/> No			
2. Tiered Network ⁽¹⁾	<input type="checkbox"/> Yes	<input type="checkbox"/> No			
3. NivaBupaOne ⁽²⁾	<input type="checkbox"/> Yes	<input type="checkbox"/> No			
4. Annual Health Check-up ⁽²⁾ (Only Cashless)	<input type="checkbox"/> Yes	<input type="checkbox"/> No			
5. Annual Health Check-up ⁽²⁾ (Cashless + Reimbursement))	<input type="checkbox"/> Yes	<input type="checkbox"/> No			
6. HeadsUp ⁽¹⁾	<input type="checkbox"/> Yes	<input type="checkbox"/> No			
7. Hospital Daily Cash	<input type="checkbox"/> Yes	<input type="checkbox"/> No			
8. Claim Safeguard+	<input type="checkbox"/> Yes	<input type="checkbox"/> No			
9. Third Medical Opinion	<input type="checkbox"/> Yes	<input type="checkbox"/> No			
10. Second Medical Opinion - Express	<input type="checkbox"/> Yes	<input type="checkbox"/> No			
11. Medical Equipment	<input type="checkbox"/> Yes	<input type="checkbox"/> No			
12. Emotional Wellness for Adults	<input type="checkbox"/> Yes	<input type="checkbox"/> No			
13. Mind Wellness Counselling	<input type="checkbox"/> Yes	<input type="checkbox"/> No			
14. Sexual Health Wellness	<input type="checkbox"/> Yes	<input type="checkbox"/> No			
15. Health Risk Assessment	<input type="checkbox"/> Yes	<input type="checkbox"/> No			
16. Accident Care	<input type="checkbox"/> Yes	<input type="checkbox"/> No			
17. Health Vouchers	<input type="checkbox"/> Yes	<input type="checkbox"/> No			
18. Compassionate Visit	<input type="checkbox"/> Yes	<input type="checkbox"/> No			
19. Flight-Mode	<input type="checkbox"/> Yes	<input type="checkbox"/> No			
20. Vaccination Cover	<input type="checkbox"/> Yes	<input type="checkbox"/> No			
21. Convalescence Benefit	<input type="checkbox"/> Yes	<input type="checkbox"/> No			
22. Modern Treatments+ (for Classic and Select)	<input type="checkbox"/> Yes	<input type="checkbox"/> No			
23. Air Ambulance+ (for Classic and Select)	<input type="checkbox"/> Yes	<input type="checkbox"/> No			
24. Dependent Accommodation Benefit	<input type="checkbox"/> Yes	<input type="checkbox"/> No			
25. International Cover	<input type="checkbox"/> Yes; ₹ _____	<input type="checkbox"/> No			
26. Critical Illness	<input type="checkbox"/> Yes; ₹ _____	<input type="checkbox"/> No			<input type="checkbox"/> No
27. WellConsult+	<input type="checkbox"/> 1X	<input type="checkbox"/> 2X	<input type="checkbox"/> 3X	<input type="checkbox"/> 4X	<input type="checkbox"/> 5X <input type="checkbox"/> No
28. ElderOne	<input type="checkbox"/> Variant 1	<input type="checkbox"/> Variant 2	<input type="checkbox"/> Variant 3	<input type="checkbox"/> Variant 4	<input type="checkbox"/> No
29. Pre-existing Disease Wait Time Modification	<input type="checkbox"/> 12 Months	<input type="checkbox"/> 24 Months	<input type="checkbox"/> No		
30. Specific Disease Wait Time Modification	<input type="checkbox"/> 12 Months	<input type="checkbox"/> 36 Months	<input type="checkbox"/> No		
31. Co-payment ⁽³⁾	<input type="checkbox"/> 10%	<input type="checkbox"/> 20%	<input type="checkbox"/> 30%	<input type="checkbox"/> 40%	<input type="checkbox"/> 50% <input type="checkbox"/> No
32. Annual Aggregate Deductible ⁽³⁾	<input type="checkbox"/> ₹10,000	<input type="checkbox"/> ₹ 20,000	<input type="checkbox"/> ₹ 30,000	<input type="checkbox"/> ₹ 50,000	<input type="checkbox"/> ₹ 1,00,000
	<input type="checkbox"/> ₹ 2,00,000	<input type="checkbox"/> ₹ 3,00,000	<input type="checkbox"/> ₹ 4,00,000	<input type="checkbox"/> ₹ 5,00,000	<input type="checkbox"/> No
33. Post-Hospitalization Modification	<input type="checkbox"/> 30 Days	<input type="checkbox"/> 60 Days	<input type="checkbox"/> 90 Days	<input type="checkbox"/> 270 Days	<input type="checkbox"/> 365 Days
34. Pre-Hospitalization Modification	<input type="checkbox"/> 30 Days	<input type="checkbox"/> 90 Days	<input type="checkbox"/> 180 Days	<input type="checkbox"/> No	
35. Initial Wait Period Modification	<input type="checkbox"/> 7 Days	<input type="checkbox"/> 10 Days	<input type="checkbox"/> 15 Days	<input type="checkbox"/> No	
36. Wellness for Women	<input type="checkbox"/> Plan 1	<input type="checkbox"/> Plan 2	<input type="checkbox"/> Plan 3	<input type="checkbox"/> Plan 4	<input type="checkbox"/> Plan 5 <input type="checkbox"/> Plan 6 <input type="checkbox"/> No

37. EyeGuard	<input type="checkbox"/> Plan 1 <input type="checkbox"/> Plan 2 <input type="checkbox"/> Plan 3 <input type="checkbox"/> Plan 4 <input type="checkbox"/> Plan 5 <input type="checkbox"/> Plan 6 <input type="checkbox"/> Plan 7 <input type="checkbox"/> No												
38. Live-Fit	<input type="checkbox"/> Plan 1 <input type="checkbox"/> Plan 2 <input type="checkbox"/> Plan 3 <input type="checkbox"/> Plan 4 <input type="checkbox"/> Plan 5 <input type="checkbox"/> Plan 6 <input type="checkbox"/> Plan 7 <input type="checkbox"/> Plan 8 <input type="checkbox"/> Plan 9 <input type="checkbox"/> Plan 10 <input type="checkbox"/> Plan 11 <input type="checkbox"/> Plan 12 <input type="checkbox"/> No												
39. Personal Accident ⁽⁵⁾ For Unlimited Base Sum Insured Option: Sum Insured Options: Up to ₹1 Crore, in multiples of ₹5 Lakhs	<input type="checkbox"/> Yes; ₹_____ <input type="checkbox"/> No For Base Sum Insured Options ₹5 Lacs & ₹10 Lacs (choose from below options) <input type="checkbox"/> 1X <input type="checkbox"/> 2X <input type="checkbox"/> 3X <input type="checkbox"/> 4X <input type="checkbox"/> 5X <table border="1"> <tr> <td>Applicant 1</td> <td>Applicant 2</td> <td>Applicant 3</td> <td>Applicant 4</td> <td>Applicant 5</td> <td>Applicant 6</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> </table>	Applicant 1	Applicant 2	Applicant 3	Applicant 4	Applicant 5	Applicant 6	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Applicant 1	Applicant 2	Applicant 3	Applicant 4	Applicant 5	Applicant 6								
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>								
PA Opted for													
40. Personal Accident Lite ⁽⁵⁾ For Unlimited Base Sum Insured Option: Sum Insured Options: Up to ₹1 Crore, in multiples of ₹5 Lakhs	<input type="checkbox"/> Yes; ₹_____ <input type="checkbox"/> No For Base Sum Insured Options ₹5 Lacs & ₹10 Lacs (choose from below options) <input type="checkbox"/> 1X <input type="checkbox"/> 2X <input type="checkbox"/> 3X <input type="checkbox"/> 4X <input type="checkbox"/> 5X <table border="1"> <tr> <td>Applicant 1</td> <td>Applicant 2</td> <td>Applicant 3</td> <td>Applicant 4</td> <td>Applicant 5</td> <td>Applicant 6</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> </table>	Applicant 1	Applicant 2	Applicant 3	Applicant 4	Applicant 5	Applicant 6	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Applicant 1	Applicant 2	Applicant 3	Applicant 4	Applicant 5	Applicant 6								
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>								
PA Opted for													
41. Personal Accident Pro ⁽⁵⁾ For Unlimited Base Sum Insured Option: Sum Insured Options: Up to ₹1 Crore, in multiples of ₹5 Lakhs	<input type="checkbox"/> Yes; ₹_____ <input type="checkbox"/> No For Base Sum Insured Options ₹5 Lacs & ₹10 Lacs (choose from below options) <input type="checkbox"/> 1X <input type="checkbox"/> 2X <input type="checkbox"/> 3X <input type="checkbox"/> 4X <input type="checkbox"/> 5X <table border="1"> <tr> <td>Applicant 1</td> <td>Applicant 2</td> <td>Applicant 3</td> <td>Applicant 4</td> <td>Applicant 5</td> <td>Applicant 6</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> </table>	Applicant 1	Applicant 2	Applicant 3	Applicant 4	Applicant 5	Applicant 6	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Applicant 1	Applicant 2	Applicant 3	Applicant 4	Applicant 5	Applicant 6								
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>								
PA Opted for													
42. Borderless ⁽⁴⁾ Sum Insured Options: Classic: NA; Select: up to ₹10 Lacs Elite: Up to to ₹50 Lacs Black: Up to ₹5 Crore	<input type="checkbox"/> Yes; ₹_____ <input type="checkbox"/> No												
For Base Sum Insured Options of - ₹5 Lacs: ₹5 Lacs Only - ₹10 Lacs: ₹5 Lacs or ₹10 Lacs													
Co-payment	<input type="checkbox"/> 0% <input type="checkbox"/> 20% <input type="checkbox"/> 30% <input type="checkbox"/> 40% <input type="checkbox"/> 50%												
43. Borderless for Specific Illness ⁽⁴⁾ Sum Insured Options: Classic: NA; Select: up to ₹10 Lacs Elite: Up to to ₹50 Lacs Black: Up to ₹5 Crore	<input type="checkbox"/> Yes; ₹_____ <input type="checkbox"/> No												
For Base Sum Insured Options of - ₹5 Lacs: ₹5 Lacs Only - ₹10 Lacs: ₹5 Lacs or ₹10 Lacs													
Co-payment	<input type="checkbox"/> 0% <input type="checkbox"/> 20% <input type="checkbox"/> 30% <input type="checkbox"/> 40% <input type="checkbox"/> 50%												

#Family Floater sum insured in common for all insured members. Floater means individually or collectively, all insured members can claim to this limit. (1) either Tiered Network or HeadsUp benefit can be opted in the policy (2) Either NivaBupaOne or Annual Health Check-up benefit can be opted in the policy. (3) Either Co-payment or Annual Aggregate Deductible can be opted in a policy (4) Either Borderless or Borderless for Specific Illness can be opted in a policy. (5) Only one of the benefits can be opted from Personal Accident or Personal Accident Lite or Personal Accident Pro.

4. Portability

Policy Number	Insurance Company	Risk Start Dats	Risk end date	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 requested	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 policy)

5. 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 Name	Date of Birth	Relationship with the Proposer	Address, mobile number and email ID of Nominee	Appointee Name (if nominee is less than 18 years of age)

Bank details of Nominee: Beneficiary Name:

Bank name Account type Savings Current

Account number IFSC Code

6. 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 share information on medical conditions													
Please answer the following questions for each applicant. Please circle Yes (Y) or No (N)										Applicant Number			
										1	2	3	4
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.										Y	N	Y	N
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	N	Y	N
iii. Does the Applicant have diabetes or pre-diabetes or has he/she EVER had high blood sugar?										Y	N	Y	N
iv. Does the Applicant have Hypertension or High Blood Pressure?										Y	N	Y	N
v. Has the Applicant ever been diagnosed or treated for any genetic / hereditary disorders or HIV / AIDS?										Y	N	Y	N
vi. Has the Applicant ever been diagnosed or treated for any mental/ psychiatric disorders?										Y	N	Y	N
vii. 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?										Y	N	Y	N

SECTION B: (Please fill this section only if the Applicant smokes or consumes tobacco / gutkha/pan masala or alcohol)	i. Chewable tobacco / Gutkha / Pan Masala. If yes, please specify number of pouches per day		ii. Alcohol. If yes, please specify number ml per week			iii. Cigarettes / Bidi / Cigar. If yes, please specify consumption per day	
	1-10	> 10	<= 450	> 450	Daily Drinker	1-10	> 10
Applicant 1							
Applicant 2							
Applicant 3							
Applicant 4							
Applicant 5							
Applicant 6							

SECTION C: For questions marked Yes (Y) in Section A, please specify following information:										
Applicant Number	Details of symptom(s) or investigation(s) or diagnosis or procedure / surgery undergone					Medication(s)	Dosage	Current status (e.g. Complete/ partial recovery or ongoing treatment)	Treating doctor's name & contact details	Documents attached (Yes/No)
	If Dia- betes HbA1c Level	If High blood pressure BP Level		Any Other Details	Onset date (DD/ MM/ YYYY)					
		Systolic	Diastolic							

7. Declaration (Please read carefully and put a check mark against each before signing the proposal form)

- ☐ 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 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.
- ☐ I/We authorize the Company to share information pertaining to my / our proposal including the medical records of the Insured / Proposer for the sole purpose of Service Delivery with our empaneled provider.

Date Place Signature of the Proposer

8. Vernacular 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:

Name of the Witness: Signature of the Witness: Mobile number of the Witness:

Signature of the Proposer:

9. Proposer 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 and complete.

Signature of the Proposer

10. Premium Details (for office use only)

Premium payment option	<input type="checkbox"/> Cheque	<input type="checkbox"/> Demand Draft	<input type="checkbox"/> Credit card / Debit card	<input type="checkbox"/> Net Banking	<input type="checkbox"/> Cash	<input type="checkbox"/> Others
Premium amount	<input type="text"/>	Online payment transaction ID:	<input type="text"/>	Date	<input type="text"/>	<input type="text"/>
Bank name/branch	<input type="text"/>	Niva Bupa branch location	<input type="text"/>			
Code No.	<input type="text"/>	Business sourced by: Advisor/DST/Corporate Agency/Other Channels				
Code No	<input type="text"/>					
Name	<input type="text"/>					
Proposal received on:	<input type="text"/>	Customer ID:	<input type="text"/>			
Is Proposer or the applicant a staff?	<input type="checkbox"/> Yes	<input type="checkbox"/> No				

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

Branch Code	<input type="text"/>	SP Code	<input type="text"/>	RM/LG code	<input type="text"/>
Customer account number	<input type="text"/>				

12. Insurance 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

13. 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.
- 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.

14. Rural and Social Sector Category (if applicable):

ASHA Worker ☐

MGNREGA Worker ☐

15. ABHA ID

Member Name	Do you have ABHA ID?		ABHA ID	Consent to share Medical records with insurers/TPA's through ABHA	
	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="text"/>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="text"/>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="text"/>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="text"/>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="text"/>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="text"/>	<input type="checkbox"/> Yes	<input type="checkbox"/> No

16. Details for Refund & Payment of Claims

Option to receive payment: ☐ Bank Transfer

Name of the Beneficiary

Bank name

Account number

Account Type

IFSC Code

Niva Bupa Health Insurance Company Limited; Registered office:- C-98, First Floor, Lajpat Nagar, Part 1, New Delhi-110024
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Product Name: ReAssure 3.0, Product UIN: NBHHLIP26047V012526

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 Rs. _____ dated _____ drawn 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

Product Name: ReAssure 3.0, Product UIN: NBHHLIP26047V012526