

Saral Suraksha Bima, Niva Bupa Health Insurance Co. Ltd. - Proposal Form

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 it's 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- PROPOSER DETAILS:

Name F I R S T N A M E M I D D L E N A M E L A S T N A M E

Gender Male Female Third Gender Date of Birth D D M M Y Y Y Y

Address

Land Mark City

District State

Pin-code Email Id

Mobile. Account number

PAN No. (for premium above Rs. 50,000 in cash and Rs. 1 Lac through other modes) Nationality

Occupation: Salaried Self-employed Student Housewife Other, please specify _____

Annual income (Rs) _____ CKYC number (optional): _____

- I will do my bit to preserve the planet for children. I will go green. Send me soft copy only. Strictly no paper please
- I wish to have this Policy credited to an eIA.
Existing E-Insurance Account No. _____ Insurance Repository Name (you have opened your account with)
1. M/s NSDL Database Management Limited 2. M/s Central Insurance Repository Limited
3. M/s Karvy Insurance Repository Limited 4. M/s CAMS Repository Services Limited (Please select any one) Or
- If you wish us to help open an eIA account for you, please fill details in sec 9, NEFT & Bank details Or
- I do not have an eIA and do not wish to open one
- I 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, policy related information or any other commercial communication.

Are you or any of the proposed applicants a politically exposed person (PEP) Yes No
#PEP is someone 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)

2- DETAILS OF APPLICANTS & PLAN SELECTION:

Applicant Number	Name	Gender (Male/Female/Other)	Height (Feet & Inc.)	Weight (Kg)	Date of Birth (dd/mm/yyyy)	Mobile Number	Relationship to Proposer	Sum insured Individual
1.								
2.								
3.								
4.								
5.								
6.								

3- COVERAGE SELECTION:

Base coverage:	
Policy type:	<input type="checkbox"/> Individual
Number of lives to be covered:	Adults _____ Children _____
Death (Base Sum Insured)	
Permanent Total Disability (PTD)	Up to Base Sum Insured
Permanent Partial Disability (PPD)	Up to Base Sum Insured
Policy term:	<input type="checkbox"/> 1 Year
Optional coverage:	
Temporary Total Disability (TTD)	<input type="checkbox"/> YES <input type="checkbox"/> NO
Hospitalisation Expenses due to Accident	<input type="checkbox"/> YES <input type="checkbox"/> NO
Education Grant	<input type="checkbox"/> YES <input type="checkbox"/> NO

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

5- MEDICAL, HABITS AND PAST PROPOSAL INFORMATION:

In respect of any of the persons proposed to be insured:	Member 1	Member 2	Member 3	Member 4	Member 5	Member 6
Are you in good health and/or not suffering from any mental/physical impairment and/or deformity and/or disablement since or after birth?	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO

6- DECLARATION:

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.

If the Proposer has signed in vernacular: The content of this form have been explained by me, Name of the person certifying in Language, 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 Witness _____

7- 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 _____ under my instruction and I found all information to be correct & complete.

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: _____

14- 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 _____

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