Health Assurance Proposal Form

(URN: 002)

Please fill up this form in CAPITAL LETTERS for self and each proposed insured person. If you require additional space to answer any question on this Proposal Form, please attach additional sheets of paper and indicate on the additional sheet the question number to which the information being provided pertains.

1. Proposer Details*

Title Name

Current Address

Landmark City

District State Pin Code

Landline Mobile No.

Email ID PAN No.

Nationality Annual Income (Rs.) Salaried Self Employed

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

Bank Details:

Bank Name Branch

City Account No.

IFSC Code Account Type Savings Current

Details of Electronic Insurance Account (eIA)

Do you wish to have this policy credited to an e-Insurance account? (Please select any one)

No I do not have an e-insurance account and do not wish to open one

Yes Credit this policy to my e-Insurance account

Rural and Social Sector Category (if applicable):

ASHA Worker MGNREGA Worker

If Yes, Please share existing E-Insurance Account No.

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

1. NSDL 2. CIRL 3. KARVY 4. CAMS (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).

*Proposer must be covered under the insurance policy and he/she must be more than 18 years of age.

2. Coverage Selection

Benefit Type (Please tick the relevant boxes. You can choose multiple benefits.)

Family Combinations : 1A 1A+1C 1A+2C 2A 2A+1C 2A+2C

AccidentCare# : Sum Insured (Rs.)

Accident Temporary Total Disability (TTD) : Yes No Sum Insured^ (Rs.)

Accident Hospitalization

CritiCare# : Sum Insured (Rs.) Option 1 Option 2

HospiCash : Daily HospiCash Limit (Rs)

Policy Term : 1 Year 2 Year 3 Year

#For AccidentCare and CritiCare: Maximum sum insured that can be opted would be up to 12 times of the annual income of the proposer if salaried or up to 15 times of the annual income of the proposer if self employed. AccidentCare would not be available to dependent children below 2 years. CritiCare would not be available for dependent children.
For salaried individuals, annual income considered would be on Fixed CTC (Cost to Company excluding bonuses and commissions) basis.

^Sum Insured for Total Temporary Disability (TTD) shall be between Rs. 1 lac to Rs. 20 lacs (in multiple of Rs. 50,000), however TTD Sum Insured cannot exceed lower of 2 times of annual income or AccidentCare Sum Insured. Annual income is actual cost to company excluding overtime, bonuses, tips, commissions, allowances, special compensations, income from other sources or any components of variable pay that the Primary Insured may have otherwise been eligible to receive.

3. Details of the Proposed Insured Person(s)

Insured No. 1	Name	Date of Birth (DD/MM/YYYY)	Height (Inch)	Weight (Kg)	Waistline (Inch)

Gender (M/F)	Relationship with Proposer	Occupation:	Education:	Risk Class*

Insured No. 2	Name	Date of Birth (DD/MM/YYYY)	Height (Inch)	Weight (Kg)	Waistline (Inch)
Gender (M/F)	Relationship with Proposer	Occupation:	Education:		Risk Class*

Insured No. 3	Name	Date of Birth (DD/MM/YYYY)	Height (Inch)	Weight (Kg)	Waistline (Inch)
Gender (M/F)	Relationship with Proposer	Occupation:	Education:		Risk Class*

Insured No. 4	Name	Date of Birth (DD/MM/YYYY)	Height (Inch)	Weight (Kg)	Waistline (Inch)
Gender (M/F)	Relationship with Proposer	Occupation:	Education:		Risk Class*

*For risk class II, there will be a 50% loading on the premium. Applicable only in case of AccidentCare coverage basis the occupation of the Policyholder.

4. Nomination (for Primary Insured)

Nominee Name	Date of Birth	Relationship with Proposer	Address, mobile number and email ID of Nominee	Appointee Name (if nominee is less than 18 year of age)
			Address Ph. No.	

Nominee Bank Details:

Bank Name _____ Branch _____ IFSC Code _____

City _____ Account No. _____ Account Type ☐ Savings ☐ Current

5. Medical History

Section A: Medical Information

	To be answered in case of CritiCare and/or HospiCash. In case only AccidentCare is opted, Please answer Q1 only.	Insured No.(Please provide answer as Yes/No against the applicant member)			
		1	2	3	4
1	Are you in good health and/or not suffering from any mental/physical impairment and/or deformity and/or disablement since or after birth?	Y/N	Y/N	Y/N	Y/N
2	Have you been advised bed rest or hospitalisation for more than 7 days for any symptoms that have affected your daily activities?	Y/N	Y/N	Y/N	Y/N
3	Have you suffered or currently suffering from any discomfort/symptom for more than 5 days for which you have not taken any consultation or are planning to do so?	Y/N	Y/N	Y/N	Y/N
4	Have you ever been advised or currently on any treatment or medication on a daily basis lasting longer than 7 days or weekly or monthly basis?	Y/N	Y/N	Y/N	Y/N
5	Have you ever undergone or been advised any of the following investigations (other than routine health check up): TMT, angiography, echo cardiography, endoscopy, CT scan, MRI, FNAC, biopsy, etc.?	Y/N	Y/N	Y/N	Y/N
6	Have you ever undergone or planning to have any operation or surgery?	Y/N	Y/N	Y/N	Y/N
7	Do you have hypertension and/or diabetes and/ or high cholesterol and/or heart problem and/or thyroid disorder?	Y/N	Y/N	Y/N	Y/N
8	Have you ever been diagnosed with any form of cancer? Have you ever been advised to undergo any screening to rule out potential cancer diagnosis other than routine screening ?	Y/N	Y/N	Y/N	Y/N
9	Have you ever consumed or currently consuming any tobacco related products like cigerrette/ gutkha-paan or alcohol or any other narcotics on a daily or a weekly basis lasting longer than a month?	Y/N	Y/N	Y/N	Y/N

To be answered in case of female life to be insured:

10	Are you currently pregnant and/or undergone/undergoing any form of fertility treatment and/or given birth by caesarean section?	Y/N	Y/N	Y/N	Y/N
11	Have you ever had any gynecological complications associated with breast, menstrual cycle, conception and/or pregnancy and/or undergone PAP smear, mammogram other than routine examination ?	Y/N	Y/N	Y/N	Y/N

Section B: (applicable only for CritiCare and/or HospiCash) Please provide details if Q1 is answered as 'No' and /or questions from Q2 to Q11 in Section A is/are answered as 'Yes'.
Name and details of Illness/Medicine/ Test/ Surgery/ Injury/Disability/Deformity/ Impairment.

Insured No.	Medical Question No.	Type of Ailment	Exact Diagnosis & Investigation Done	Diagnosis Date	Date of Consultation	Details of Treatment/ History of Hospitalisation	Doctor & Hospital Name & Phone No. and whether Hospitalised for it

(If you require additional space to answer any question on this proposal form, please attach additional sheets of paper and indicate on the additional sheet the question number to which the information is being provided pertains.)

Section C:

1. Is the Insured Person / Proposer a Politically Exposed Person (PEP)#? (if yes, kindly fill the PEP Questionnaire) ☐ Yes ☐ No
2. Do you have any history of conviction under any criminal proceedings in India and/or abroad? ☐ Yes ☐ No

#PEP are individuals who are or have been entrusted with prominent public functions i.e. heads/ ministers of central or state govt. senior politicians, senior govt. judicial or military officials, senior executives of govt. companies, important party officials, immediate family member or above persons (would include spouse, parents, children, spouse's parents or siblings and close associates of PEPs).

Section D: Family History* (applicable for CritiCare and HospiCash coverage)

Have your parents, brothers or sisters had cancer, diabetes, hypertension (high blood pressure), heart or kidney disease, polycystic kidney disease, mental or nervous disorder (including alzheimer's disease), stroke, multiple sclerosis, motor neuron disease or any other hereditary disorders which is persistent / long in nature? ☐ Yes ☐ No

Insured No.	Relationship with the Proposer	Disease or Disorder (if any)	Age (if living)	Age at Onset	Cause of Death (if applicable)	Age at Death (if applicable)

*To be provided for adult member only

6. Family Physician's Details

Family Physician's Name _____ Contact No. 1 _____ Contact No. 2 _____

7. Existing Insurance Details

Are you or any person(s) proposed to be insured already insured under Health Insurance/ Personal Accident Policy with Niva Bupa Health Insurance Company Limited or any other insurance Company. ☐ Yes ☐ No

If yes, since when have you been continuously insured DD /MM /YYYY

Insured No.	Insurance Company Name	Policy No./ Application No.	Insured From (Date)	To (Date)	Sum Insured	Claims Details (if any)

8. Declaration (Please read carefully and put a check mark against each before signing)

☐ 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 insurance company and that the policy will come into force only after full receipt of the premium chargeable.

☐ I/We further declare that I/we 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/We declare and consent to the company seeking medical information from any doctor or from a hospital who at anytime has attended on the life to be insured/ proposer or from any past or present employer concerning anything which affects the physical or mental health of the life to be assured /proposer and seeking information from any insurance company to which an application for insurance onthe life to be assured /proposer has been made for the purpose of underwriting the proposal and/or claim settlement.

☐ I /We authorize the company to share information pertaining to my proposal including the medical records for the sole purpose of proposal underwriting and /or claims settlement and with any Government, Our Service Provider 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.

☐ I/We hereby declare, on my behalf and on behalf of all person 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/We am/are authorized to propose on behalf of other persons.

Date: _____ Place: _____ Signature of the Proposer _____

9. Authorization for Electronic Policy Fulfillment and Service Communications

I would like to protect my environment and would like to help save paper by authorizing Niva Bupa Heath Insurance Company Limited to send all my policy and service related communication to the email ID as mentioned in the application form. ☐ Yes ☐ No

10. 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 Witness: _____

Signature of the Witness _____ Signature of the Proposer _____

11. ABHA ID

Member Name	Do you have ABHA ID?	ABHA ID	Consent to share Medical records with insurers/TPA's through ABHA
	☐ Yes ☐ No	_ _ _ - _ _ _ _ - _ _ _ _ - _ _ _ _	☐ Yes ☐ No
	☐ Yes ☐ No	_ _ _ - _ _ _ _ - _ _ _ _ - _ _ _ _	☐ Yes ☐ No
	☐ Yes ☐ No	_ _ _ - _ _ _ _ - _ _ _ _ - _ _ _ _	☐ Yes ☐ No
	☐ Yes ☐ No	_ _ _ - _ _ _ _ - _ _ _ _ - _ _ _ _	☐ Yes ☐ No

12. Details for Refund & Payment of Claims

Option to receive payment: ☐ **Bank Transfer**

Name of Beneficiary

Bank Name Account No.

IFSC Code Account Type ☐ Savings ☐ Current

For Official Use Only

Premium Payment Details: ☐ Cash ☐ Cheque /DD No. ☐ Credit Card

☐ Online/Direct Debit Transaction ID ____________________ Amount

Date (DD/MM/YYYY) Bank Name/ Branch

Niva Bupa Branch Location Code No.

Business Sourced By: Advisor/DST/Corporate Agency/other channels Code No.

Name Code No.

Proposal Received on Date Customer ID

Processed by ____________________ Date DD/MM/YYYY Approved by ____________________ Date DD/MM/YYYY

Additional Details for Bancassurance Channel Only

Branch Code SP Code RM/LG Code

Customer's Account No.____________________

Insurance Advisor's Report

1. Are you related to the proposer? ☐ Yes ☐ No If Yes, nature of relationship? ____________________
2. Since when do you know the proposer? ☐ Years ☐ Months
3. Are you satisfied with the identity of the proposer? ☐ Yes ☐ No
4. Does the proposer or any proposed insured have any physical deformity/defect or mental retardation? ☐ Yes ☐ No
5. Have you explained the exclusions of the policy and has the Proposer personally completed the health declaration? ☐ Yes ☐ No
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

Date: (DD/MM/YYYY)

Signature of the Insurance Advisor

STATUTORY WARNING :

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 or 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 continuing a policy accept any rebate except such rebate as may be allowed in accordance with the published prospectus or tables of the Insurer. (2) Any person making default in complying with the provisions of this section shall liable for a penalty, which may extend to ten lakh rupees.

Niva Bupa Heath Insurance Company Limited

Insurance is a subject matter of solicitation. Niva Bupa Health Insurance Company Limited (*formerly known as Max Bupa Health Insurance Company Limited*) (IRDAI Registration Number 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. Registered office:- C-98, First Floor, Lajpat Nagar, Part 1, New Delhi-110024, Customer Helpline: 1860-500-8888. Website: www.nivabupa.com. CIN: U66000DL2008PLC182918.

Note: Proposer is liable to inform Niva Bupa if there is any change in the nature of job of any of the Insured Persons during the policy period.

niva Bupa Health Insurance

Acknowledgment

Proposal From No. Date D D M M Y Y Y Y

We acknowledge with thanks the receipt of your proposal and amount by Cash/Cheque/Demand Draft/ Other ____________ of amount of Rs. ____________ Dated ____________ Drawn on ____________

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 out 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 whatsoever if permium 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. if any, received from you without interest.

Singnature of the Receiver and office seal

Key Feature Document

Niva Bupa is dedicated to being fair and transparent to its customers. This document summarizes the key features and waiting periods in your policy. Please read it carefully to understand your policy better.

1. AccidentCare Cover

If an insured person dies or sustains any injury due to an accident then AccidentCare cover will help through the following benefits:

a. Death Cover :	Payable on death.
b. Permanent Total Disability :	Payable for a permanent disablement that affects the ability to work or loss of use of limbs or sight.
c. Permanent Partial Disability :	Payable for a permanent injury that affects part of your body e.g: loss of use of hand or foot or loss of speech or hearing etc.
d. Child Education Benefit :	Payable under family option for up to 2 dependent children in the event of death or permanent total disability.
e. Funeral Expenses :	Payable on death.
f. Temporary Total Disability : (optional benefit)	Payable for a disability due to which the insured person is unable to attend his usual occupation.
g. Accident Hospitalisation : (optional benefit)	Payable for hospitalisation expenses due to an accident.
h. Sum Insured (SI) Eligibility :	Self - 100% of SI Spouse - 50% of SI or Rs 10 lacs (whichever is lower) Children - 20% of SI or Rs 5 lacs (whichever is lower)

2. CritiCare Cover

If an insured person suffers any of the 20 Critical Illnesses covered in the policy (such as Cancer, Heart Attack, Open Chest CABG, Multiple Sclerosis etc.), Niva Bupa will pay the Sum Insured as per the benefit option selected.

a. Benefit Options :	**i. Benefit Option 1** - Sum Insured payable as lump sum **ii. Benefit Option 2** - Sum Insured payable as lump sum plus 10% of the Sum Insured payable each year for subsequent 5 years
b. Sum Insured (SI) Eligibility :	Self - 100% of SI Spouse - 100% of SI
c. Initial Waiting Period :	90 days from the date of commencement of the coverage, i.e. the benefit would not be payable if the signs or symptoms occurred during the first 90 days or earlier.
d. Waiting period for Pre-existing Diseases :	Benefits will not be available for pre-existing diseases until 36 months of continuous coverage have elapsed since the inception of the first policy.
e. Cost of Pre Policy Medical Check-up (PPMC):	In case the proposal for CritiCare is declined, customer will have to bear 100% of the cost incurred towards PPMC

3. HospiCash Cover

If an insured person is hospitalised, then Niva Bupa will pay the daily allowance (as opted) for each continuous and completed period of 24 hours of hospitalisation. In case the insured person is admitted to the Intensive Care Unit (ICU) of a hospital, then Niva Bupa will pay twice the daily allowance opted.

a. Sum Insured (SI) Eligibility:	Self - 100% of chosen Daily HospiCash limit Spouse - 100% of chosen Daily HospiCash limit Children - 50% of chosen Daily HospiCash limit We shall make payment under this benefit up to maximum of 45 days for an insured person in a policy year, including maximum 7 days of admission in ICU.
b. Initial Waiting Period :	30 days from the date of commencement of the coverage. There will be no initial waiting period in case of hospitalization due to an accident.
c. Waiting Period for Pre-Existing Diseases :	Benefits will not be available for pre-existing diseases until 36 months of continuous coverage have elapsed since the inception of the first policy.

Key Feature Document

d. Specific Waiting Period : 24 months waiting period for specific conditions / treatments such as Cataract, Sinusitis, Stones in biliary and urinary systems, Arthritis, Diabetes and related complications etc.

e. Free Look Provision :

Free Look provision: If you do not agree to the terms and conditions of the policy, you may cancel the policy, stating your reasons within 30 days of receipt of the policy document provided no claims have been made under any benefits. The free look provision is not applicable at the time of renewal of the policy.

NOTE: THESE ARE ONLY SUMMARY OF THE COVERS OFFERED. PLEASE REFER TO THE POLICY WORDINGS FOR COMPLETE DETAILS BEFORE CONCLUDING A SALE. THIS DOCUMENT IS ONLY AN INDICATOR FOR KEY BENEFITS IN THE POLICY.

Date: _____

Place: _____

Signature of Proposer: _____

Name of Proposer: _____