niva Bupa Health Insurance

GoActive™ Proposal Form

URN: 003

210150001303

1. Proposer Details:

Title Name

DOB (D D M M Y Y Y Y) Gender: Male Female Other Nationality

Current address

Landmark City

District State Pincode

Landline number Mobile number

Alternate number Email ID

Aadhaar Number (Optional) PAN Number

Annual income (Rs)

Employment: Salaried Self-employed Student Housewife Other, please specify

Premium paid by Relationship with Proposer

Are you 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)

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

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 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

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).

2. Coverage Selection:

Are you applying for portability: ☐ Yes ☐ No (If "Yes", please fill the separate portability form also).
Please tick the relevant boxes:

Base coverage:

Sum Insured ☐☐☐☐☐☐☐ Policy type: ☐ Individual ☐ Family Floater

Lives to be covered: ☐ 1A ☐ 1A+1C ☐ 1A+2C ☐ 1A+3C ☐ 1A+4C ☐ 2A ☐ 2A+1C ☐ 2A+2C ☐ 2A+3C ☐ 2A+4C

Policy coverage: ☐ Zone 1: All India coverage ☐ Zone 2: All India coverage with co-payment applicable for Mumbai, Delhi NCR, Kolkata & Gujarat State

(Note - If you select Zone 2, then 20% co-payment will apply for treatment in Mumbai, Delhi NCR, Kolkata & Gujarat State. This Zone-wise co-payment shall not be applicable on OPD Consultation, Emergency Ambulance, Health Checkup / Diagnostic Tests, Second Medical Opinion, Behavioral Assistance Program and Personal Accident Cover.)

Annual Aggregate Deductible: ☐ Yes ☐ No If yes, then please choose the deductible amount:

☐ Rs. 25,000 ☐ Rs. 50,000 ☐ Rs. 1 lac ☐ Rs. 2 lac ☐ Rs. 3 lac ☐ Rs. 5 lac ☐ Rs. 10 lac

Optional coverage under the product:

a. **Health Coach** (Personalized health coaching and renewal discount basis calculation of health score): ☐ Yes ☐ No

If yes, then please choose the lives to be covered: ☐ Primary Insured Person ☐ Primary Insured Person along with spouse

☐ In the event of opting for 'Health Coach' coverage, I agree that the Company may provide my relevant details to the service provider to contact me to provide the services under the benefit. I further agree and consent that tracking details on the mobile application are required by the Company and the service provider to track, record and calculate my eligibility to receive the benefits. I declare and consent through my own free will and without any duress that the Company and its authorized service provider may access and record these details on a periodic basis and use these details for calculating and according the benefits under the Policy

b. **I-Protect** (Lifetime Increase in Sum Insured @10% every year): ☐ Yes ☐ No

c. **Personal Accident Cover:** ☐ Yes ☐ No

If yes, then please choose the lives to be covered: ☐ Primary Insured Person ☐ Primary Insured Person along with spouse

For base coverage Sum Insured Rs. 5 lacs and above, please select Personal Accident Sum Insured ☐ 25 lac ☐ 50 lac
(The default Personal Accident Sum Insured is Rs. 10 lac for base coverage Sum Insured of Rs. 1 lac or 2 lacs and Rs. 25 lac for Base coverage Sum Insured of Rs. 3 lacs or 4 lacs.)

3. Details Of Applicants For Insurance:

Adult 1

Name ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Gender ☐ Male ☐ Female ☐ Other Height ☐☐ (ft) ☐☐ (inch) Weight ☐☐☐ (kg)

Waistline ☐☐ (inch) Date of Birth D D M M Y Y Y Y Mobile number[@] (Mandatory) ☐☐☐☐☐☐☐☐☐☐

Relationship to Proposer (Please tick option): Self/Spouse/Son/Daughter-in-law/Daughter/Son-in-law/Father/Mother/Father-in-law/Mother-in-law/Grandfather/Grandmother/Grandson/Granddaughter/Brother/Sister/Sister-in-law/Brother-in-law/Nephew/Niece/Employer-Employee

Occupation ☐☐☐☐☐☐☐☐☐☐☐☐☐ Please tick if not Indian ☐ Please tick if PEP[#] ☐

Adult 2

Name ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Gender ☐ Male ☐ Female ☐ Other Height ☐☐ (ft) ☐☐ (inch) Weight ☐☐☐ (kg)

Waistline ☐☐ (inch) Date of Birth D D M M Y Y Y Y Mobile number[@] (Mandatory) ☐☐☐☐☐☐☐☐☐☐

Relationship: Spouse of Adult 1 ☐

Occupation ☐☐☐☐☐☐☐☐☐☐☐☐☐ Please tick if not Indian ☐ Please tick if PEP[#] ☐

Child 1

Name

Gender Male Female Other Height (ft) (inch) Weight (kg)

Waistline (inch) Date of Birth D D M M Y Y Y Y Relationship: Son of Adult 1 Doughter of Adult 1

Please tick if not Indian Please tick if PEP#

Child 2

Name

Gender Male Female Other Height (ft) (inch) Weight (kg)

Waistline (inch) Date of Birth D D M M Y Y Y Y Relationship: Son of Adult 1 Doughter of Adult 1

Please tick if not Indian Please tick if PEP#

Child 3

Name

Gender Male Female Other Height (ft) (inch) Weight (kg)

Waistline (inch) Date of Birth D D M M Y Y Y Y Relationship: Son of Adult 1 Doughter of Adult 1

Please tick if not Indian Please tick if PEP#

Child 4

Name

Gender Male Female Other Height (ft) (inch) Weight (kg)

Waistline (inch) Date of Birth D D M M Y Y Y Y Relationship: Son of Adult 1 Doughter of Adult 1

Please tick if not Indian Please tick if PEP#

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 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

@Please provide mobile number for each adult member as it will be used for appointment booking services.

5. Medical And Habits Information

IMPORTANT: Please ensure to answer all the questions in this section truthfully and completely as the information You provide here shall form basis of underwriting by Niva Bupa. Please note any incomplete, incorrect, partially correct information may affect your claim and/or coverage. Please answer questions under Sections A and B by circling Yes (Y) or No (N). Provide details of any disclosure in Section C.

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											
	A1		A2		C1		C2		C3		C4	
1. Has the applicant taken any consultation for or been treated for any pre-existing conditions or had any of the following?												
i. Any Surgery or surgical procedures	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N
ii. Hospitalization for more than 5 days	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N
iii. Medication (including oral/ inhalation/injection/Topical) for more than 14 days	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N
iv. Adverse findings to any diagnostic test or investigation or any persistent symptoms in the past 6 months other than common cold, flu, infections, minor injury or other minor ailments	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N
v. High or low Blood Pressure/Diabetes or Abnormal Blood Sugar	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N
vi. Any Cancer, Chronic Kidney disease, Psychiatric, Neurological (brain/spine) or related disorders	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N
The question below is to be responded only by females between the age 18-50 years												
2. Are you currently pregnant and/ or have had any complications in the current or earlier pregnancies?	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N

SECTION B: Please share information on habits

Please answer the following questions for each applicant. **Please circle Yes (Y) or No (N)**	Applicant Number											
	A1		A2		C1		C2		C3		C4	
Does the applicant consume any of the following:	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N
i. Chewable tobacco / Gutkha / Pan Masala - please specify number of pouches per week												
ii. Alcohol - please specify number of glasses / ml per week												
iii. Cigarettes / Bidi / Cigar - please specify consumption per week												

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		Duration of condition	Medication(s)	Dosage	Current status (e.g. Complete /partial recovery or ongoing treatment)	Treating doctor's name & contact details	Documents attached (Yes/No)
	Details	Onset date (DD/MM/YYYY)						

Has any proposal for life, health, hospital daily cash, Personal Accident 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?	Applicant Number											
	A1		A2		C1		C2		C3		C4	
	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N

7. Authorization For Electronic Policy Fulfillment And Service Communications

Would you 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? ☐ Yes ☐ No

8. 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.

9. 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 forthe sole purpose of Service Delivery with our empaneled provider.

Date D D M M Y Y Y Y Place _____ Signature of the Proposer

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. Proposer Declaration

(Certification where for any reason, the proposal and other connected papers are not filled in by the prospect).
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

12. Premium Details (for office use only)

Premium payment option ☐ Cheque ☐ Demand Draft ☐ Credit card

Premium amount

Online payment transaction ID:

D D M M Y Y Y Y

Bank name/ branch

Niva Bupa branch location

Code No.

Business sourced by: Advisor/DST/Corporate Agency/Other Channels

Code No.

Name

Customer ID:

Is Proposer or the applicant a staff? ☐ Yes ☐ No

13. Additional Details For Bancassurance Channel Only (For Office Use Only)

Branch Code

SP Code

RM/LG code

Customer account number

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 Months
3. Are you satisfied with the identity of the Proposer? ☐ Yes ☐ No
4. Does the Proposer or any applicant have any physical deformity/defect or mental retardation? ☐ Yes ☐ No
5. Have you explained the conditions for renewability, exclusions of the Policy and has the Proposer personally completed the health declaration? ☐ Yes ☐ No
6. Do you recommend acceptance of this proposal form considering all the factors including moral hazard? ☐ Yes ☐ No
7. 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? ☐ Yes ☐ No

Date D D M M Y Y Y Y

Signature of the Insurance Advisor

15. 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.

16. 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
	☐ Yes ☐ No	- - -	☐ Yes ☐ No
	☐ Yes ☐ No	- - -	☐ Yes ☐ No

17. Details for Refund & Payment of Claims

Option to receive payment: ☐ Bank Transfer

Name of the Beneficiary

Bank name

Account number

IFSC Code

Account type:

Niva Bupa Health Insurance Company Limited; Registered office:- C-98, First Floor, Lajpat Nagar, Part 1, New Delhi-110024

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Key Feature Document (KFD) – GoActive™

Niva Bupa is dedicated to being fair and transparent with its customers. This document summarizes the key features of your Policy, however it does not replace your Policy contract and we encourage you to read all the details of your Policy before you conclude the purchase of this product.

Go Active provides you with a comprehensive range of benefits, ranging from hospitalisation to outpatient benefits to personal accident cover, including multiple optional benefits to better meet your needs.

The following base benefits are provided, subject to some limits and exclusions as specified in your Policy:

- Inpatient care at a hospital, including room rent and ICU charges
- Pre and post hospitalization expenses for 90 and 180 days respectively
- Living organ transplant
- Domiciliary hospitalization and home health care services
- Emergency ground ambulance
- Re-fill benefit in case the Sum Insured is exhausted because of claims made during the policy year, for different illnesses / conditions or for other Insured members covered under the Policy
- Choice of Annual health check-up package or diagnostic tests of your choice
- Out-patient consultations subject to a maximum per consultation limit
- Second medical opinion from experts on the diagnosis of specified illnesses or planned surgery or surgical procedures
- Counseling sessions to provide support on stress management, nutrition, parenting and others
- Pharmacy and Diagnostic booking services
- Early Age Discount: A discount of 10% of the base premium (i.e. premium before any loading or discount, excluding taxes for the base cover) shall be given at the time of First Policy and all subsequent renewals for lifetime, if the age of the eldest member at the time of inception of the First Policy is less than or equal to 35 years. Such discount also applies to the family floater policy premium if applicable
- Choice of opting for zone coverage basis which a 20% co-payment will / will not apply for treatment in Mumbai (including Navi Mumbai and Thane), Delhi NCR, Kolkata & Gujarat State
- Modern Treatments covered, subject to limits

The following optional benefits are provided subject to some limits and exclusions as specified in your Policy:

- I-Protect: Increase in Sum Insured by 10% of the Base Sum Insured on every renewal. The benefit will be provided for every policy year as long as the policy is renewed or until you request for opting out of this benefit.
- Health Coach - Wellness services to keep yourself fit and healthy, including a personal health coach. Based on your health score, a premium discount of up to 20% of the base premium (i.e. premium excluding taxes and optional benefits) may apply at the time of renewal.
- Personal Accident coverage against accidental death, permanent total and partial disability

Please note that an additional annual premium is charged for the optional benefits

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Note that waiting periods are applicable as per the Policy:

- Pre-existing Disease waiting period of 36 months since inception of the policy and continuous renewal
- Initial Waiting Period of 30 days unless the treatment needed is the result of an Accident
- Specific Waiting Period of 24 months for some listed illnesses, unless the condition is directly caused by Cancer
- (covered after Initial Waiting Period of 30 days) or an Accident (covered from day 1)
- Please note that Waiting Periods shall not apply to Annual health check-up or diagnostic tests, second medical opinion,
- out-patient consultations, counseling sessions and optional benefits if opted for

Note that standards exclusions are applicable as set out in the Policy contract. In addition, based on the underwriting results, some specific exclusions might also apply to your Policy.

Other key features of your Policy are as follows:

- Individual or family floater cover (up to 2 adults and 4 children), with any addition or deletion of member(s) in the Policy being done only at the time of renewal.
- Lifelong renewability of your Policy subject to your confirmation and timely payment of the due premium.
- Your renewal premium will increase every year as your age increases but will not alter based on your claim experience. Renewal premium rates for the product may be revised in future subject to IRDAI approval and in accordance with the IRDAI's rules and regulations as applicable from time to time.
- In case your proposal is declined for issuance, you will bear 100% of the cost incurred towards the cost of Pre Policy Medical Check-up (PPMC).

NOTES:

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.

Premium: kindly deposit the premium amount through a secure mode of payment in the name of Niva Bupa Health Insurance Company Limited.

Please also note that the Out-patient consultation benefit under this product is available within our network of doctors in selected cities only on a cashless and reimbursement basis. Please check the list of cities before buying the policy on our website www.nivabupa.com or by calling our customer helpline number 1860-500-8888.

_____ I hereby consent to and authorize the Company to make welcome calls, service calls or any other communication (electronic or otherwise) with respect to the proposed or existing policy of Company from time to time.

Date: _____ Signature of Proposer: _____

Place: _____ Name of Proposer: _____

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Acknowledgment By The Company

Application No. Date D D M M Y Y Y Y

We acknowledge with thanks the receipt of your proposal and amount by Cheque/Demand Draft/Others _____ of amount of Rs. dated D D M M Y Y Y Y drawn on D D M M Y Y Y Y
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 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.

Signature of the receiver and office seal